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CONTENTS

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PUBLIC HEALTH NURSING

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Keeping Abreast with the Times

IT WOULD BE foolhardy to attempt to foretell the outcome of the armistice discussions taking place in Korea at this writing. Of one thing we are sure: All civilized men hope sincerely for peace, a peace based on mutual understanding and good faith. Anything less than such a peace will be but an armed truce. And it may be many years before we can be sure of our final direction.

This last year, the year of the Korean emergency, has led us in nursing to do some careful self study. With the experience of World War II so recent we know too well what pressures in combination with shortages do to services. Having this in mind our national committee, in planning for the current emergency, recommended priorities of staff and programs. The recommendations were widely reviewed and were issued as a guide, since everyone realized communities would have to make adjustments to meet their own local situations.

If an armistice is arrived at, it is natural for a period of relaxation to set in in all our affairs—affairs of state, family affairs, and also professional affairs. Already our more thoughtful statesmen are warning us that we must proceed warily, that we cannot move out of the emergency situation because of a cease fire truce in one small area when basic problems of world cooperation remain unsolved. And it behooves us in a vital health field to move forward with plans for community services with proper discretion also.

The statement "Recommended Adjustments," published in May 1951, said: "Agencies that provide public health nursing services have the responsibility of reviewing their programs and procedures in light of changing conditions." As a matter of fact, the stepped-up mobilization is only one of many changing conditions which face us in the midcentury. Those agencies which have already put into effect some emergency measures may find it prudent to continue these for a long enough period to evaluate their results. But other agencies which have been slower in making changes may find that the cessation of hostilities is the very point around which to introduce some departures in administrative practices. For example, agencies which have hesitated to employ practical nurses, thinking that their instruction and guidance might be additional burdens on the professional staff, may find prepared practical nurses available in their communities this fall, and also find that their staffs are anxious to start teaming up with practical nurses.

CONCERN WITH CIVIL defense brought home to many public health nurses the great advantages and values in group teaching. It also brought home to administrators a realization of how few nurses are truly skilled in group work. Even if the emergency miraculously should end tomorrow we should not be living up to our responsibilities if agencies do not provide further opportunities for all the staff to gain proficiency in group work. This means, among other things, planning for more groups, not only the old standby, mothers' clubs, but also parents classes, classes for diabetics, and home nursing courses.

If the word *adjustment* carries with it a connotation of second best and of doing without let's drop "adjustment" with the end of the Korean incident. But let's carry on with all that is good in the adjustments worked out by your national committee. Let's call it keeping abreast with the times. And keeping step in public health nursing in 1951 means continuous analyzing, studying, planning, and evaluating one's program and reporting to the community.

A Local Community Holds its Own White House Conference

HELEN M. WALLACE, M.D.

THE MIDCENTURY White House Conference on Children and Youth held in December 1950 was the fifth such conference; each decade since 1909 there has been a conference to consider the welfare of children. The first conference had as its primary concern the dependent child. It set forth principles in this field which have guided welfare workers. It also was instrumental in the creation of the Federal Children's Bureau in 1912. The second conference held in 1919 emphasized standards of child welfare and focused attention upon child labor legislation, protection of mothers and children, educational opportunity, and children in need of special care. This conference in its concern for maternal and child health helped to pave the way for the Sheppard-Towner Act, under which the federal government provided funds to aid the states in the care of mothers and children from 1921 to 1929.

The 1930 conference brought together representatives of all fields concerned with the health and welfare of children—medical, public health, education, and social service. The findings represented the most comprehensive diagnosis of the needs of *all* children and statement of goals for their welfare and protection. This conference was a factor in the organization of the American Academy of Pediatrics. The many reports resulting from this conference have been a major resource for all groups working in the field of child care. The fourth conference held in 1940 as war approached had as its main consideration the welfare of children in a democracy. It defined objectives which would build toward democratic citizenship for children and uphold the strengths of democracy in their environment and it emphasized the need to mobilize all community resources at all levels to strengthen services to children.

The 1950 conference had as its theme the development of a healthy personality in children and youth. It was the culmination of effort over two years of workers in all phases of child care at the federal, state, and local levels. The conference adopted sixty-seven resolutions relating to the overall theme and in addition set up eight principles for effecting appropriate follow-up action. Following are two of these principles:

That the chief operating groups upon which the responsibility for follow-up shall fall will be existing organizations—national, state, and local.

That provision for continuity shall be implemented by . . . providing for state and local follow-up organization.

Within a month after the federal White House Conference was held the Brooklyn Council for Social Planning, which represents ninety-six civic, health, and welfare agencies in the borough, assumed leadership and began to plan Brooklyn's White House Conference. This report will describe the planning and program of the Brooklyn Conference on Children and Youth.

The planning phase

Representatives of over 100 health, welfare, spiritual, youth, and civic organizations met at a luncheon to hear a report of the White House Conference; lay members and youth representatives participated in this report. There was consensus that Brooklyn as a local community should hold a conference of its own to examine its needs and then to take the necessary steps to meet such needs.

Dr. Wallace is chief, Division of Maternity and Newborn, New York City Department of Health.

The theme of the Brooklyn conference was to be the same as that of the federal conference —the development of a healthy personality in children and youth. A date for the one-day conference was agreed upon, coinciding with the annual meeting of the Brooklyn Council for Social Planning in April 1951, and a steering committee was appointed. This steering committee met at almost weekly intervals over a three-month period to plan the details of the conference with the fulltime conference secretary appointed by the Brooklyn Council for Social Planning. The program of the conference was set up as follows:

1. Afternoon session: Individual panel discussions
   Panel groups: Birth to two years
   Two to six years
   Six to twelve years
   Twelve to eighteen years
2. Dinner meeting
3. Evening session
   Review of the material presented in the afternoon panel discussions
   Discussion of this summary by a youth panel, "As Youth Sees It"
   "The Job Ahead" discussed by Dr. Leona Baumgartner, assistant commissioner for maternal and child health services, New York City Department of Health.

A panel chairman was appointed for each of the four afternoon discussion groups. Each panel chairman set up an advisory committee to assist in the planning of the individual panel discussions. These advisory committees held several meetings during the three-month interim period. Speakers, discussers, and recorders were selected for each panel, and each speaker had his own smaller advisory group to assist him in the collection of the facts demonstrating the needs, in the discussion of the needs, and in formulation of recommendations to meet the needs. For example, in the panel group, "Birth to Two Years," of which the writer was chairman, an advisory committee was appointed consisting of Brooklyn leaders in obstetrics, pediatrics, nursing, (education, public health, clinical) social service, child psychiatry, nutrition, hospital administration, welfare and child-caring agencies, the county medical societies, the state university medical school in Brooklyn, the Department of Health, the American National Red Cross, and lay representatives. This advisory committee selected the topics to be covered—the care of pregnant women, hospital care for mothers and newborn infants both fullterm and premature, health supervision of infants and young children, care of infants and young children away from their own home, and the psychological needs and problems of each of these groups. The problem of adoptions was selected as a "reserve" topic, in the event that there was little discussion from the group attending the panel. The committee then designated the panel speakers, the panel recorder, and summarizer.

Plans were made for securing a youth leader and members of the youth panel. Arrangements were also made for circularizing the program and invitation to the conference to all of the health, welfare, hospital, civic, and lay groups in Brooklyn.

The factfinding phase

Obviously, needs may only be met and programs planned when the facts are known. Thus factfinding became one of the most important preconference steps. Two of the four panel leaders prepared background statistical data for two panels, and each panel discusser became a "factfinder" in the preparation of his own material. For example, in the panel "Birth to Two Years," a factual sheet was prepared and distributed to all persons attending this panel, comparing the borough of Brooklyn with that of the entire New York City in such items as live births; premature births; fetal deaths; infant deaths; neonatal deaths; maternal deaths; diphtheria, whooping cough, and tetanus cases and deaths; children with reported congenital syphilis and age at reporting of the disease; infants registered at the Health Department's child health stations; number of child health stations; average waiting period for registration in child health stations; number of newborn infants visited in the home after hospital discharge by public health nurses; number of children under two years of age awaiting placement in foster care.

In the panel group "Two to Six Years," the factual sheet contained data on the Brooklyn population in this age group; the number of children receiving public assistance; the num-

ber of children receiving health supervision in the Department of Health child health stations; the dental facilities and their waiting lists; the number of kindergartens and their waiting lists; the number of day care centers and their waiting lists; the number of children in foster care agencies and their waiting lists; the number of children's psychiatric clinics and their waiting lists; the number of homemakers and the additional applications not able to be met; a report on the status of the public housing program with the current waiting list; and types of services for mentally and physically handicapped children virtually unmet. As one would expect, recourse was made to as many public and private agencies as possible in the collection of the facts.

Highlights of the Conference

Approximately 1200 people attended the Brooklyn conference. Highlights of the material discussed follow.

Panel I. Birth to Two Years emphasized the need to improve services for the pregnant woman—prenatal care, nutrition including monetary supplementation for the marginal group, counseling and teaching of expectant parents. Minimum hospital standards for mothers and newborn infants were discussed, including rooming-in; the need for skilled obstetric, pediatric and nursing personnel and policies; the need for certain potentially lifesaving ancillary services such as blood, laboratory, and x-ray facilities, and trained personnel in the areas of anesthesia and neonatal resuscitation, the need of premature centers. The need of continuing health supervision of the infant after hospital discharge was emphasized from the physical and psychological aspects. The need of love, security, and understanding for all children was repeatedly pointed out.

Panel II. Two to Six Years. This panel was represented by a psychiatrist, a psychologist, a pediatrician, a mother, an administrator of a day care program, and a child welfare worker in city government. There was general agreement that considerable progress in physical care had been made, but that there was great need for emphasis on the emotional aspects of care and of mental hygiene services for the preschool child. There is need for more resources for parent education. It was agreed that group experience was desirable for young children, and that there was tremendous need for more day care centers and kindergartens. Another need expressed was for more foster homes, especially for the younger child. Free dental service for the preschool group was also emphasized. The panel thought that while there were enough physicians in Brooklyn there was need for more pediatricians, especially more with orientation in the psychological aspects of child care.

Panel III. Six to Twelve Years. This panel was represented by a psychiatrist, a psychologist, a pediatrician, a child guidance worker, a spiritual leader, an educator, and a family caseworker. It was pointed out that the establishment of a healthy personality in the child while still within the family environment was a necessary foundation for meeting problems on entering school and on entering the outside world. The necessity of a religious foundation for children and the importance of group work were stressed, as were also the need for improving the participation of the parents, the need for more mental hygiene resources, the need to coordinate the work between schools and their communities, the need for more funds to train personnel and to hire personnel when trained. There was considerable recognition of the great importance of parent instruction, and of expansion of health facilities, clinics, and social agencies.

Panel IV. Twelve to Eighteen Years. This panel was represented by an educator, a psychiatrist, a mental health worker, a spiritual leader, and a parent. The roles of the school, the church, the home, and the community were discussed in considering the special problems of teen-agers. There was agreement that youth should be given responsibilities as well as rights. It was emphasized that the existing school curriculum was inadequate to meet the needs of youth going out into the business world and that there was need to develop more facilities for vocational training and guidance. The lack of psychiatric services for adolescents was pointed out.

Each panel was handled differently, varying

from a plan of prepared talks followed by group discussion by the general participants, to a plan in which the general participants were brought into the discussion immediately by the panel members raising questions. Each method seemed to work satisfactorily.

Following the afternoon panel sessions, the panel chairmen and recorders met to prepare an overall summary which was presented at the evening meeting and discussed by the youth panel composed of nine high school students.

The highlight of the evening session was "The Job Ahead," in which Dr. Baumgartner presented three great strengths in our democracy as exemplified by the White House Conferences. They are (1) the people's conferences (2) the great belief in the future and in our children (3) the equally important belief in the value of the individual and of the right of the individual to maximum liberty and freedom. The approach in the conferences was that of private and public agencies teaming up to get the job done as quickly as possible. It was pointed out that there is great concern over the problem of fostering the development of healthy personalities among our children; physical ills have largely been conquered but worries about behavior have not yet been. Some facts were presented showing that there are more children than ever before, and that parents are younger. Most families are small ones, but most of our children live in large families and in families with incomes of less than $3,000 a year. These children live in areas where services are less likely to be readily available. Parents are asking for help and these needs are not being met. Considerable progress has been made in the last fifty years, but much more remains to be done. In addition to the maldistribution of services there is a shortage of adequately trained workers and there is need for adequate salaries for such workers. Dr. Baumgartner concluded by presenting her personal "seven-point program of action" and by suggesting that each person establish his own individual program of action in order to mobilize as many forces and groups to do the job which needs to be done.

Principles In Planning A Local White House Conference

The above brief description of the Brooklyn White House Conference may be summarized into the following principles:

1. The need for cooperation of *all* health, welfare, social, medical, nursing, religious, nutrition, educational, recreational, psychiatric workers and agencies, both official and voluntary.
2. The need for inclusion of strong representation from the lay public and from youth.
3. The need to gather the facts to demonstrate needs.
4. The need for some one agency or group to take the initiative and coordinate the activities of all groups and individuals.
5. The need for establishment of an advisory committee or committees, both to plan the conference itself and to assist in the preparation of technical material to be presented.

Future plans

One might rightfully inquire about the tangible results of a community effort such as the White House Conference, either nationally or locally. At the local level, at the time of writing this report, it is much too soon to evaluate the effects of the Brooklyn White House Conference. However, certain steps are planned: (1) The material presented at the conference is to be published and widely distributed. An editorial committee has already been formed. (2) It is expected that the Brooklyn Council for Social Planning will again assert its leadership in the implementation of the needs expressed and gaps found at the conference.

As a matter of interest, one local area in Brooklyn has already approached the Brooklyn Council for Social Planning for assistance in planning its own White House Conference. This type of chain reaction is obviously the best method of arousing community interest and support, so that the needs of the people may be recognized and plans made for meeting them more quickly.

The Philosophy of Administrative Process And the Role of the Consultant

JOHN C. KIDNEIGH

THE PHILOSOPHY OF administrative process implies acceptance of a commonly understood definition of the term administration, a deep understanding of the objective, and of the methods and procedures to be used in achieving the objective.

The term administration is rather vague. It is defined in different ways by different writers. It begins to have clearer meaning when preceded by a descriptive term. For example, business administration, public administration, or social administration are less vague than administration. Each of these examples is less clear than more specific terms such as manufacturing plant administration, tax and revenue administration, or social work administration.

There are certain elements common to administration wherever it is found. Because of these relatively few common elements some persons have been led to believe that a person trained in the common elements of administration can be a successful executive in differing organized agencies or enterprises. That is, some have been led to assume that a successful business executive can be a successful social work agency executive, or that a successful public welfare executive can be a successful manufacturing plant executive. This is an erroneous assumption. Some organized enterprises are more alike than others and hence have more elements in common, but the transition from being an executive in one to a similar position in the other is not easy even when the two organizations differ but little.

Administration can be defined as the process of transforming social policy into social services. This definition also includes the process of utilizing the experience gained in transforming social policy into social services to make recommendations that will modify the social policy. It is thus a two-way process: (1) a process of transforming policy into concrete social services and (2) the use of experience in recommending modification of policy.

Social work administration is not primarily concerned with the establishment of social policy, although it is frequently involved in it. The establishment of social policy is a legislative function that must be performed by some appropriate authority, body, or board; in the case of the public agency, the legislative body, and in the case of the private agency, the agency board in cooperation with appropriate community authorities and the agency executive.

Social work administration is the process of executing that policy, during the course of which the experience gained is made available to the policymaking authority for purposes of providing a sound base for the continuation or modification of that policy. It is recognized that social policy is usually expressed in general terms. It therefore becomes the responsibility of social work administration to interpret and define in greater detail the established policy.

Mr. Kidneigh is director, School of Social Work, University of Minnesota. *This paper is based on the talks given by the author at the* NOPHN *regional meetings in Omaha and New Orleans in May and June 1951.*

Coordination implies an aim or objective. But it does not follow, even where there is a true mutual interest, a mutual understanding, and a degree of mutual participation, that each and every member of the organization does in fact carry in his mind a deep understanding of the objective and how it may be attained. In social work a "deep understanding of the objective" goes to the heart of our fundamental concepts of the nature of man, the function of society, and the role of social work. The "how it may be attained" is related to the professional methods we have developed which we call casework, social group work, and community organization. In other words, the "deep understanding of the objective" is what we believe, and the "how it may be attained" is the procedure we see as necessary to achieve the objective.

Optimum or maximum performance cannot be expected unless the persons in our agency hold relatively the same views concerning the objective, and accept relatively the same methods or procedures for working toward that objective. It seems obvious that if we wish to increase the effective use of staff time we must give considerable attention to in-service training in addition to designing organizational patterns. We must capitalize upon the "socially constructive passion in every man," as Mary Parker Follett put it, to assure that every member of the agency staff is deeply imbued with respect for the dignity of each human being, that every staff member behaves from a sincere conviction that eligible persons have a right to social services and benefits, and that every staff member dedicates himself to those measures that will reduce human suffering and preserve human values. Our inservice training must not only concern itself with imparting these basic concepts, it must also provide methods for learning how to carry out the duties assigned in such a way that the procedures will be consonant with the essential philosophy of social work.

In the field of medicine the objective is to make the patient well, but the procedure and its application call for thorough training and wide experience. In the game of football the objective is to win, but the procedure and its application call for thorough training and much practice in teamwork. In social work the objective is that people shall have "economic wellbeing and the deeper source of happiness that is self-realization,"* and the procedure and its application call for thorough training, wide experience, and much practice in teamwork.

Administration is an art

Administration is also an art in human relations. In order to be successful in the administrative process both executives and workers in the agency must identify and use principles of human relationships and methods of dealing with those relationships on a person-to-person basis and a person-to-group basis. It is important that all persons in the administrative process understand principles of human relationships and methods of dealing with those relationships.

An illustration of this is the use of the principle of individualization, the principle of breaking a complex problem down into its parts, the principle of growth through relationships, the recognition of ambivalence, the recognition that the conscious and the unconscious ego have ways of defending themselves through silence, illness, denial, self-condemnation, projection, or retreat; the recognition that frustration is painful and may result in regression to infantile reactions; the recognition that feelings and emotions rather than reason usually govern human action; the recognition that all behavior is purposive; the recognition that professional social work is practiced within a consciously controlled relationship between person to person or person to group.

Above and beyond the principles available from the disciplines of social casework and social group work, however, are additional knowledges and skills in the area of human relations which are essential to the administrative process. These methods have commonly been described as public relations. They include skill in interpreting the social

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* Youngdahl, Benjamin E. Social Work as a Profession. *Social Work Yearbook, 1949.* New York, Russell Sage Foundation, 1949, p. 497-506.

agency, its program and methods, to individuals and groups not in an immediate face-to-face relationship, and skill in securing the return flow of opinions and attitudes about the social agency and its program. They also include skill in dealing with employees and fellow workers as responsible individuals engaged in the cooperative enterprise of working to achieve agency objectives. This involves, among other things, leadership qualities characterized by skill in arousing the enthusiasm and creative abilities of fellow workers and employees; organizing the emotions of the group's members around the plan or the cause in the interest of developing a sentiment of loyalty to the objectives; institutionalizing the organization rather than personalizing it; intelligent use of conference methods; and main reliance on the principle of growth from within. In essence, all of these relationship principles assist in making the social work administration process essentially democracy in action.

Translating policy into service

Administration is a process of translating policy into services. A comprehension of the whole process serves as a frame of reference for understanding the dynamics of many interrelated subprocesses. Each of these subprocesses should synchronize so as to provide movement toward the chosen goal of transforming a particular set of social policies into appropriate social services. In other words, if the subprocesses within the social work administration process mesh harmoniously, movement toward the achievement of agency objectives is assured. Casework and/or group work usually play the principal role among these processes and other subprocesses must synchronize with them in order to assure movement toward the chosen goal.

The broad outlines of this totality of process may be sketched as follows (recognizing, of course, that these are arbitrary designations because all of the subprocesses are going on simultaneously, but they may be thus separated for purposes of discussion, analysis, and understanding).

1. *The process of getting facts pertinent to the agency objectives and program as a basis for establishing decisions.* This includes research and reporting of various kinds which provide accuracy, comprehensiveness, pertinency, and integrity of the presentation of the facts. In this connection consideration must be given to the definiteness and comparability of units of measurement; to the definition and clarity of terms; to the cause-effect relationships involved; to the relationship of the facts to the situation and environment as well as to the process or activity being studied; to the problems of source materials, tabulation, and publication; and also to the relationship of fact getting to morale and efficiency.

2. *The process of analyzing the available pertinent facts and making guesses about the future, that is, to make estimates as to probable future happenings that may bear upon the program of the social work agency.* This is essentially an analysis of trends. It is common for man to attempt to form judgments about the probable trend of future events, but an attempt to be exact about the future is a comparatively new phenomenon. Forecasting is an inescapable responsibility of administration even though the methods at our disposal for forecasting purposes are as yet embryonic. Statistics is an indispensable tool because objective synthesization is an absolute necessity.

3. *The process of identifying and selecting for action one of several alternatives available to the social work agency considering the forecasts that have been made.* This essentially is making a diagnosis and prognosis. It is here that skill in collaboration and sound judgment is put to the test.

4. *On the basis of the alternative selected, the process of making plans for effectively carrying forward the objectives of the agency.* Plans are made to blueprint the proposed use of personnel, material, and equipment. This planning process also includes financial planning with the establishment of a budget which translates the services to be rendered into units of cost, or, to put it another way, shows the proposed cost for personnel, material, and equipment thought essential to the production of the social services contemplated. Within the limitations of finances available, plans are modified or shaped so as most nearly to match the purposes, objectives, and policy of the social work agency enterprise. Furthermore, it is recognized that a plan for any given social agency cannot be made appropriately without reference to the relationship of the given social agency to other agencies and forces with which the social agency must cooperate. A good plan should have clearly defined objectives;

it should be simple; it should be flexible; it should be well balanced; it should provide for the use of available resources to the utmost before providing for new authorities, new departments, or new resources; and it should serve as a frame of reference against which activities can be measured.

5. *Under the plan adopted the process of arranging for a division of work into such units that each unit can be assigned to one person for execution.* Ordinarily this division of work calls for the arrangement of duties and responsibilities in such a fashion as to produce a hierarchy of duty and responsibility. If the social work agency is a large one it may call for the establishment of staff services as contrasted with, and as a supplement to, line services. This process is essentially a process of blueprinting an organizational structure and developing procedures to standardize certain operations. In other words, this process describes the work to be done and details how each person in the organization is to do his part. Included, therefore, is the process of developing job descriptions, classification plans, manuals of procedure, and standards for the evaluation of performance. Furthermore, this process sets the stage for an adequate delegation of authority and responsibility, and a clear delineation of the function of each worker.

6. *The process of recruiting, selecting, appointing, inducting, training, supervising, and coordinating personnel essential to the enterprise and in accordance with the plan and the organized division of work.* Included in this process is the establishment of personnel practices and policies.

7. *The establishment and continuous use of appropriate measures to assure that all activity in the social work agency contributes to the attainment of the selected objectives of the agency program.* This process includes methods of communication, supervision, supervisory training, consultative and staff services, evaluation of performance, and other measures of personnel and financial control.

8. *The collection, recording, and analysis of pertinent facts during the course of the total process that will serve as a basis for* accountability, improving the process of administration, and developing recommendations for modification of social policy.

Administration applies to a given kind of program

Administration applies in any given instance to a given kind of program. It is specific to the kind of program being administered. In other words, I do not believe that a person competent in business administration will necessarily be successful as a social work agency executive or that a person successful as a social work agency executive will necessarily be able to administer a public health nursing program. Among other things specific understanding of agency functions, relationship to legislative authority, variations in process because of particular settings, and knowledge of financial arrangements that apply to a particular program must be clearly and thoroughly understood.

Role of the Consultant

In discussing the role of the consultant I have three points I wish to make.

1. There is a distinction between the technical meanings of the terms "staff" and "line."
2. The role of consultant is a "staff" function.
3. Consultation is primarily a teaching job.

A "line" function applies to the responsible executive supervisors and workers in whose hands has been placed the official responsibility of the agency for carrying out the program and objectives of the agency, whereas the "staff" function is to provide special information, expert advice, and assisting service to the "line" officer in the discharge of the duties, functions, and operations of a given agency. To illustrate, in an analogy to the human body it could be said that the "line" officer is the brain, the hands, the torso, the voice of the organization, while the "staff" officer is an extension of the personality of the "line" officer providing extra expertness in brain power, additional eyes and ears to lend a higher degree of expertness to the "line" officer in the discharge of his functions.

A homely illustration can be given by citing the prehistoric incident of two cavemen who decided to cooperate with each other in removing a boulder from the mouth of the cave of one of the two. Hence, an organization was formed, an organization being the association of two or more human beings with a common purpose. The two cavemen struggled to remove the stone and found their efforts in-

effectual, so they sought the advice of an older graybearded caveman neighbor who was an expert in stone-raising. He gave them information and advice about how to take hold of the stone, how to use leverage to break the stone loose from its imbedded position. Following his advice the two cavemen took hold of the stone, one of them giving the signal when to lift (hence, he was the supervisor) and by their combined efforts, following the advice and counsel of the aged expert, were successful in removing the stone. We see here a graphic illustration of the "staff" function. The elderly expert did not so much as put a hand on the stone, but his expert information and advice made possible the performance of the function of the organization.

Consultant is a "staff" worker

In considering the consultant as a "staff" official we must remember that every position, whether "line" or "staff," consists of at least three functions:

1. The function of determining what to do: This function may be circumscribed more or less by the place within the hierarchal chain of authority where it may be found.

2. The doing of the something which was determined or, in other words, the execution of the duties: This phase of every position is the one most easily recognized by the observer and frequently takes up most of the time of the employee.

3. The decision of questions which may arise in the course of performance in conformity with predetermined rules and practice: This function is found in nearly every position but more predominantly in the supervisory positions.

By comparison the consultant as "staff" official has these three functions plus three other functions:

1. Primarily the function of giving information so that the "line" official may be in a position to make wise decisions.

2. To give advice which follows naturally out of providing expert information so that the "line" official can make sound judgments.

3. To analyze and review on-going agency operations exercising the authority of ideas in helping the "line" official to provide for greater accuracy, efficiency, and integrity.

Looking at this in another way we could say that consultation, therefore, can be of three kinds or any combinations of two or more of the three:

1. Consultation on planning.

2. Consultation on operating matters.

3. Reviewing and inspecting operations in order to give consultation on operating methods.

Consultation is teaching

And, finally, consultation is primarily a teaching job. A consultant should know and apply certain elementary principles of education and the learning process; such, for example, as begin where the student is, know the subject matter yourself, make the learner want to know, start with the known, teach the simple first, then lead up to the more complicated, give reasons for doing, demonstrate how to do it correctly, encourage discussion, give the learner a chance to do it, watch him as he does it until he has learned how to do it, free him to do it in his own way, and remember that emotions and attitudes play an important part in the learning process.

We have not exhausted by any means all of the pertinent points that could be made concerning the philosophy of administrative process and the role of the consultant, but I hope that what has been presented will serve as a basis for further consideration.

* * *

The years teach much which the days never know.
—RALPH WALDO EMERSON

A VNA Considers Patients' Fees

EMILIE G. SARGENT, R.N.

THE VISITING NURSE ASSOCIATION of Detroit, like other VNAs faced with a sizable decrease in income when the MLI contract nursing service is ended in 1953, is looking for ways of replacing the cut and increasing earnings in general. In 1950, the agency received $67,391 for service to Metropolitan policy holders. This represented 13.5 percent of the agency's total income. This sum will probably be lowered by $10,000 for 1951, as insurance referrals are tending to fall off. Therefore in setting up the budget for 1951 the board agreed that the $10,000 possible decrease must be made up through increases in patients' fees. The experience in the first quarter of this year bears out the expectation that patients' fees will come to $10,395 more than in 1950.

We based our judgment that we could collect more from patients on two points. First, we believe that an individual patient's fee should reflect current costs and not those of the previous year. The maximum charge in 1950 was $2.50, which was the cost per visit agreed on with the insurance companies. This fee, of course, was based on 1949 costs and visits. Our actual cost per visit in 1950 was $2.64, and our increased expenses for 1951 would raise this cost an additional 10 percent. Therefore, our projected cost per visit for 1951 was about $3, and the board decided to set the full pay fee at that figure for service rendered in 1951.

The second basis for the agency's decision to increase fees for the fullpay patient was the result of a simple study of economic status of families served on one day in October 1950. To assist the nurses in setting fees the association uses a guide on family expense and income, prepared by the Family Budget Council, a committee of the Council of Social Agencies.* We feel that this guide has considerable validity as our agency's breakdown of the economic status of families served coincides with a similar type of breakdown for the general population in Detroit, based on data from the federal Bureau of Labor Statistics.

We sorted the records of the 457 patients visited on the day selected for the study according to economic status and then grouped the visits in each economic group according to the pay status. (See Tables 1, 2, and 3.)

It can be seen that very likely a higher percentage of the comforts group should have paid full cost and a higher percentage of the necessities group should have paid part cost. It is of interest for the future to note that 38 percent of the comforts group and 35.4 percent of the necessities group had service through insurance benefits, while only 2 percent of the poverty group had such coverage. Therefore it seems that when care is no longer available through insurance company contracting with the nursing organization, most of these families seeking nursing service in the future will be able to pay full or part fees.

Miss Sargent is executive director of the Visiting Nurse Association of Detroit.

* Copy of this material may be borrowed from NOPHN, 2 Park Avenue, New York 16, N. Y.

TABLE 1. Visits classified according to fee basis

Fee	Number of Visits	Percent of Visits
Full cost	75	16.4
Part cost	73	16.0
Insurance	110	24.1
Free	199	43.5
Total	457	100.0

TABLE 2. Visits classified according to economic status of family

Economic Status	Number of Visits	Percent of Visits
Comforts	173	37.9
Necessities	141	30.8
Poverty	143	31.3
Total	457	100.0

TABLE 3. Economic status of families classified according to payment for care

Economic Status	Full Cost Percent	Part Cost Percent	Insurance Percent	Free Percent	Total Percent
Comforts	39.0	8.0	38.0	15.0	100.0
Necessities	4.2	16.3	35.5	44.0	100.0
Poverty	0.0	5.0	2.0	93.0	100.0

TABLE 4. Percentage distribution of income by source 1941 and 1950

Source of Income	1941[a]			1950[b]		
Total income	100.0			100.0		
Earnings	54.9			43.4		
Insurance contracts		40.0			19.6	
Metropolitan Life Insurance Company			30.7			13.9
John Hancock Mutual Life			6.9			4.0
Other contracts			2.4			1.7
Patients' fees		9.0			13.1	
Public agency contracts		4.7			6.7	
Private agency contracts		1.2			4.0	
Contributed funds	45.1			56.6		
Community Chest		38.3			52.9	
Other contributions		6.8			3.7	

[a] Total income for 1941, $283,230.00.
[b] Total income for 1950, $485,723.07.

THE COMMUNITY CHESTS are concerned to know what proportion of the income loss from the Metropolitan contract they will be asked to make up. As a matter of fact, income from insurance contracts has been decreasing for some time and community chests have been gradually making up part of this loss in agencies' income. A review of the financial statements for 1941 and 1950 for the VNA of Detroit will show this clearly. (Table 4.)

A comparison of the percentage distribution of income sources of the VNA of Detroit for 1941 and 1950 shows that the ratio of earnings to total income was 11.5 percent less in 1950 than in 1941 and the ratio of income from contribution to total income was 11.5 percent more in that year. The ratio of insurance earning to the total decreased by 20 percent but was offset by an increase in the proportion of income from patients' fees, public and private contracts, and contributed sources. Income from community chest contributions in 1950 comprised 52.9 percent of the income as compared with 38.3 percent in 1941, an increase of 15 percent in community chest share of the total income.

We are convinced that the insurance principle should be applied to home nursing service. In Detroit 65 to 75 percent of hospital bills are paid through patients' insurance, 20 to 28 percent are paid directly by patients, and 3 to 4 percent by welfare or government sources. Today visiting nurse associations are carrying a heavier nursing service than

(Continued on page 482)

Puppet Nurse

MARIE A. WILSON, R.N.

"PUPPET NURSE." That's what the school children in my district call me. If you also are a school nurse probably one of your biggest problems is to make some of the basic health principles attractive to young children. Perhaps you'll be interested in a novel method I've devised—almost by accident. It is especially successful in teaching dental hygiene.

For years I've noticed, and you probably have too, that with children and puppets it's love at first sight. I make marionettes and puppets as a hobby and I've marveled at children's complete acceptance of everything a puppet says. Not so long ago I produced a new puppet, gave him a personality, and dressed him in a dentist's white coat. So far as I'm concerned he really is the one who's doing the dental teaching. I call him Dr. Jones, and by now so do my children.

Dr. Jones and I usually make an appointment with the class teacher in advance. Dr. Jones is sixteen inches high and we make quite a couple as we come marching into the classroom. By manipulating the strings I keep him nodding and weaving about as he asks and answers questions. The children are utterly bewitched by this and their attention never wanders.

"Hello there, children! Do you know who I am? Well, I'm your friend the dentist, Dr. Jones. How many of you have been to see your dentists lately?" He waits for an answer and then counts the raised hands. "Well, that's fine. I'm glad you went to see the dentist but I'm sorry if you had a toothache."

"Do you know some of the ways you can prevent toothache? One way is to see the dentist before your tooth aches. If he sees some decay beginning, he may put a small filling in so that the decay won't get larger. Do you know another way to keep your teeth in good condition?" Dr. Jones waits for answers and then waves a toothbrush. "Do you see what I have in my hand? How many of you have toothbrushes?"

Then I give a short explanation of the need for brushing teeth after each meal and, if brushing can't be done each time, about thorough rinsing of the mouth after eating.

We then discuss good diets for good teeth, and since most of the children realize that milk is one of the best foods, it is a simple matter to get them talking about milk and then to direct the discussion to green leafy

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vegetables, cereals, eggs, generous helpings of meat and fruit. Sometimes we mention spinach and that brings up another old friend, Popeye. Dr. Jones never forgets to caution about too much candy and soda pop.

The puppet and I are usually a little out of breath by this time. The children have crept closer and closer and now Dr. Jones says, "Let's sing a song about the toothbrush." This is how our song goes:

> This is the way we brush our teeth,
> Brush our teeth, brush our teeth,
> So early in the morning!
>
> This is the way we brush our teeth
> Brush our teeth, brush our teeth,
> Before we go to bed at night!

The children still cluster about and want more. But they are generous too in telling Dr. Jones about their own experiences. My favorite story is about the little boy who announced he brushed his teeth faithfully twice a day and he brushed his dog's teeth faithfully too—with the same brush. Maybe he didn't have the right method but he knew a good idea and was spreading it!

Once Dr. Jones was talking very seriously to a group of first graders when his head came off. It was really funny to see his head swinging from his body while he was still talking to the children. They enjoyed him even more than ever for losing his head over them.

These children think of the nurse and their doctors and dentists as their friends. I think when they are sent to the nurse's office for illness or advice they will not be afraid, and I hope they are forming some good health habits which they will carry through life.

Patient Fees

(Continued from page 480)

ever before because of the increasing number of patients with chronic illnesses. These patients can be cared for at home, and it is an economy to the community and the nation for them to be kept at home. Therefore some way must be found to pay for their medical and nursing care on the insurance principle. If home nursing were available on the insurance principle probably two-thirds of the families of this nation could afford to purchase it. In Detroit 32 percent of the families have an income of $5,000 or over, and 82 percent have an income of $3,000 or over. The community chest and public funds would finance the cost for those who could not pay for nursing insurance, but the sum required of them would be less than the 60 percent or more of visiting nurse associations' budgets that they now provide.

The use of the insurance principle to pay for home nursing is still in the future, but agencies must face ***now*** the problem of how to finance current and future operations in the face of a cut in income from the Metropolitan. In 1953 former MLI patients, using nursing service, should largely pay for their own nursing care. The community chest should not have to make up more than one-third of the income formerly paid by the Metropolitan. In Detroit we expect to work hard to increase earnings of all kinds, particularly patients' fees. We believe also that public funds should be more available for nursing service and we shall work to that end. We believe industrial nursing in small plants is an important service which we shall try to increase, and while we are doing these things we will also keep working with the Michigan Blue Cross and Blue Shield for a home nursing benefit.

This paper is based on a report given at the NOPHN regional conference in Providence, Rhode Island, in April 1951.

The Need for Convalescent Care for Hospitalized Acute and Chronic Illness

JEAN DOWNES AND DORIS TUCHER

IT IS GENERALLY AGREED today that the concept of preventive medicine and public health includes more than measures for improvement of community sanitation and for protection against certain acute communicable diseases. Prompt medical care for illness and early diagnosis are now considered as essential elements in an adequate community health program. Measures for preventing and shortening the period of disability from illness are also important.

The public health nurse has played an influential part in formulating and implementing the public health program. The demand for nursing service is to a considerable extent dependent upon the physician's and the public's awareness of the need and availability of such service. At the present time it is safe to assume that neither the physician nor the public requests nursing service as often as needed.

The purpose of this paper is to suggest where nursing care for illness may be most appropriate. Emphasis is placed upon hospitalized cases of acute and chronic illness and their need for convalescent care. Chronic diseases are increasing and their increase will no doubt affect the future demand for nursing service. Consequently, the data are presented separately for acute and chronic illness.

Miss Downes and Mrs. Tucher are on the staff of the Milbank Memorial Fund.

Data and Method

During a five-year period, June 1938 to May 1943, the U. S. Public Health Service and the Milbank Memorial Fund conducted a study of illness by monthly visits in a sample of families in the Eastern Health District of Baltimore, Maryland. The method of sampling has been described in detail in previous reports.[1,2] The record of illness started with the first visit to the family and each family was visited once a month thereafter.

In the studies of illness conducted by periodic canvasses of families, "illness" may be considered to include any affection or disturbance of health which persists for a considerable part of one or more days. The records of illness are statements of cases of illness reported by the household informant (usually the housewife) either as experienced by herself or as she observed them in her family. Physical defects or deformities were recorded only if disabling, or if medical attention was given them.

For all cases of illness a record was made of the nature and amount of medical service received and whether rendered by a private physician, clinic, or hospital. The causes of illness reported by the family informant were submitted to the attending physicians for confirmation or correction. The causes of illness for clinic attendance and hospital admissions were also checked against the records of

the clinic or hospital where the service was given. The only exception to this procedure was for illnesses hospitalized outside the City of Baltimore.

In this analysis of illness, cases are classified as to whether acute or chronic. Chronic illness is further subdivided and these cases are classed as either a "major" or a "minor" disease. The classification "major" chronic disease includes: heart disease, hypertension or high blood pressure, arthritis, tuberculosis, diabetes, chronic nephritis, rheumatic fever, varicose veins, chronic gallbladder disease, syphilis, malignant neoplasm, peptic ulcer, toxic goiter, epilepsy, mental deficiency, psychoses and psychoneuroses, and other important but relatively rare chronic conditions. The "minor" chronic illnesses are those of a less severe nature. Chronic sinusitis, asthma, lumbago, neuritis, neuralgia, chronic headache, and chronic indigestion are some of the illnesses in the "minor" category. For part of this analysis, minor chronic illnesses are excluded.

It should be emphasized that the category "chronic disease" in the morbidity study being reported upon includes chronic conditions which manifested themselves in illness that was severe enough to require medical care at some time and which were diagnosed either by a private physician or at a clinic or hospital. Quite different results would be obtained if all persons in the sample population were examined to detect the presence of chronic disease.

Cases of acute illness as presented represent an incidence or occurrence of illness over an average twelve-month period. On the other hand, cases of chronic illness represent a prevalence over an average twelve-month period, that is, chronic cases include those where the onset of illness occurred prior to observation as well as those where the onset occurred during observation.

Summary of Illness, Medical and Hospital Care

The data presented include the sickness records for all families observed two months or longer in the sample thirty-four blocks. Seventeen of these blocks were included in the study for a period of five years and the other seventeen for a period of three years.[2,3] The population for the total period included 20,832 person-years of observation.

The population observed for illness was considered as representative of the localities in Baltimore in which the wage-earning population lived, that is, it contained some families in relatively poor economic circumstances, wage-earning families in moderate circumstances, relatively few families in the professional class, and no families classed as wealthy.

Facilities for medical care of illness in the original Eastern Health District (Wards 6 and 7) the area from which the sample of families was drawn, included three hospitals within the district and two adjacent to it. Each of these hospitals had an outpatient service where medical care was available at a nominal cost or free if the patient was considered eligible for free care by the social service department of the hospital. Baltimore also had a city hospital where free care was available to all residents considered eligible for such care. Approximately 150 private physicians practiced regularly within the district. However, during the period of the study, 619 different private physicians served the observed population. Public health nursing services were also available in the district.

Figure 1 shows the proportion of the total illnesses that were classed as acute and

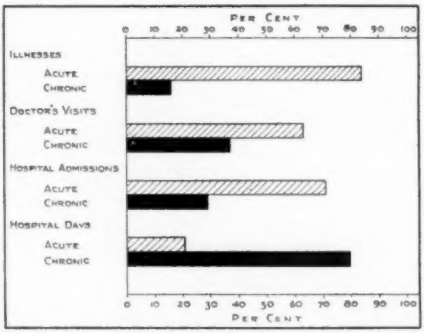

Figure 1. Proportion of the total illnesses that were acute and chronic and the proportion of the doctors' visits, hospital admissions, and hospital days that were due to these illnesses.

chronic, and the proportion of the total doctors' visits, hospital admissions, and hospital days that were due to these two types of illness. Chronic disease constituted only 16 percent of the total cases of illness. It is apparent, however, that chronic disease received a relatively high proportion of the total medical services—37 percent of the doctors' visits (excluding visits in the hospital) 29 percent of the hospital admissions, and about 80 percent of the hospital days. These data afford some evidence of the preeminence of chronic disease as a health problem.

Cause of Illness

Acute Illness. Table 1 shows the incidence of acute illness and of hospital admissions classified by certain causes (columns 1 and 2). Minor respiratory diseases constituted about 50 percent of the total illness rate but only about one-fourth of the hospital admissions. Tonsillectomy was the predominant reason for these hospitalizations. The other important causes of hospital admissions were pregnancy and complications of pregnancy, accidents, digestive diseases, and illnesses in the category, "all other causes."

Column 3 of Table 1 shows the percent of the total cases of acute illness in each class that were hospitalized. It is noteworthy that 31 percent of the pneumonia cases and 61 percent of the pregnancies and complications of pregnancy had hospital care.

The hospital days per hospital case (column 4) were relatively high for pneumonia and accidents, about seventeen days per case. Very few cases of the acute communicable diseases and of asthma were hospitalized, so the mean number of days per case for these illnesses may be greatly influenced by one or two cases with a long hospital stay.*

These data are of interest to the public health nurse because they indicate particular acute illnesses where nursing care in the home may be needed after discharge from the hospital. The data in this study are weighted by the prewar period and are not greatly affected by the present tendency to shorten the period of hospital care. For many conditions a shorter hospital stay may mean a

* The numbers upon which all rates shown in this paper are based will be found in the published paper, number 4 on the list of references.

TABLE 1. Incidence of illness, hospital admissions, and hospital days for *acute* illness, Eastern Health District of Baltimore, June 1938-May 1943

Diagnosis Class	Incidence of Illness	Incidence of Hospital Admissions	Percent of Cases Hospitalized	Hospital Days Per Hospital Case
	Rate Per 1,000 Population			
Total	1,261.4	53.5	4.2	9.9
Acute Respiratory	659.3	15.7	2.4	4.6
Minor Respiratory	651.3	13.2	2.0	2.4
Pneumonia	8.0	2.5	31.3	17.0
Accidents	122.2	3.6	2.9	16.6
Digestive Diseases	85.5	5.7	6.7	11.2
Diseases of Skin	60.4	0.9	1.5	7.3
Acute Communicable Diseases	55.2	0.5	0.9	16.2
Female Genital Diseases	23.1	2.2	9.5	12.7
Pregnancy and Complications of Pregnancy	20.7	12.7	61.4	9.5
Diseases of the Ear	20.8	1.0	4.8	13.9
Diseases of the Teeth and Gums	19.0	*		*
Asthma and Hayfever	18.7	0.1	0.5	16.3
Diseases of the Organs of Vision	17.7	0.4	2.3	9.8
All other Causes	158.8	10.7	6.7	14.2

* Only one hospital admission.

longer period than previously of convalescence in the home.

Chronic Illness. The prevalence of chronic illness and the incidence of hospital admissions by cause are shown in Table 2 (columns 1 and 2). The chronic diseases are arrayed by diagnosis groups according to their frequency of occurrence. Arthritis, heart disease, and diseases of the vascular system are the most important causes of chronic illness. However, the risk of hospitalization was greatest for heart disease, psychoses, tuberculosis, rheumatic fever, and malignant neoplasm. Also, the category, "other chronic disease," had a relatively high rate of hospitalization.

Column 3 shows the percent of cases in each illness class that were hospitalized. Psychoses, tuberculosis, malignant neoplasm, and toxic goiter were conditions with a relatively high proportion hospitalized. Those diseases recognized as usually having long durations—mental deficiency, psychoses, and tuberculosis—had the greatest number of hospital days per case per year (column 4).

It is important to point out that psychoneuroses, mental deficiency, psychoses, peptic ulcer, and toxic goiter, considered as mental and psychosomatic disorders, constitute 16 percent of the total chronic cases. From the data it is impossible to say in how many instances psychogenic factors have contributed to the production of the leading causes of chronic illness—arthritis, heart disease, and hypertensive vascular disease. It may be concluded, however, that adequate care of many chronic diseases will involve appreciation and knowledge of the importance of the emotional factors which may underlie or be involved in the specific condition suffered by an individual.

Duration of Convalescence After Hospitalization

Acute Illness. The duration of the period of convalescence is indicated by the duration of disability after discharge from the hospital. Among the total 1,114 persons hospitalized because of acute illness, 2 percent died in the hospital; 19 percent were not disabled after discharge; 39 percent were disabled but were not confined to bed; and 40 percent were disabled and confined to bed for one or more days.

Table 3 shows the mean number of disabled days per case after discharge for those in cer-

TABLE 2. Prevalence of major *chronic* disease and incidence of hospital admissions and hospital days, Eastern Health District of Baltimore, June 1938-May 1943

Diagnosis Class	Prevalence of Illness	Incidence of Hospital Admissions	Percent of Cases Hospitalized	Hospital Days Per Hospital Case Per Year
	Rate Per 1,000 Population			
Total Cases	202.3	19.7	9.7	103.5
Arthritis	40.4	0.4	1.0	23.6
Heart Disease	33.6	2.9	8.6	39.1
Hypertensive Vascular Disease and Arteriosclerosis	20.4	0.7	3.4	56.9
Psychoneurosis and Nervousness	15.1	0.8	5.3	178.2
Rheumatic Fever[1]	13.5	1.8	13.3	84.9
Varicose Veins	10.5	0.2	1.9	7.4
Gall-Bladder Disease	7.6	0.2	2.6	20.0
Diabetes	7.4	0.7	9.5	25.9
Mental Deficiency	7.1	1.0	14.1	268.3
Psychosis	5.3	2.8	52.8	259.9
Tuberculosis	5.1	2.3	45.1	142.0
Syphilis	4.6	0.2	4.3	31.0
Neoplasm (Malignant)	3.6	1.6	44.4	21.8
Peptic Ulcer	3.3	0.4	12.1	27.0
Goiter (Toxic)	1.9	0.4	21.1	49.7
Other Chronic Diseases	19.0	3.0	15.8	54.6
Also, Crippling Conditions	3.8	0.3	7.9	11.3

[1] Includes cases of rheumatic fever with rheumatic heart disease.

TABLE 3. Disabled days and bed days per disabled case of *acute* illness after discharge from hospital, Eastern Health District of Baltimore, June 1938-May 1943

Diagnosis Class	Days Per Case		
	Disabled—No Bed Disability	Disabled and Bed Disability	
		Disabled Days	Bed Days
Total	19.3	16.7	6.2
Minor Respiratory Illness	7.9	7.2	3.0
Pneumonia	15.2	42.4	11.9
Accidental Injuries	42.6	58.9	25.1
Digestive Diseases	22.4	20.4	5.5
Female Genital Disease	26.3	23.0	8.6
Pregnancy and Complications of Pregnancy	9.9	16.2	6.2
All Other Causes	23.4	15.5	6.9

TABLE 4. Disabled days and bed days per disabled case of *chronic* illness after discharge from hospital, Eastern Health District of Baltimore, June 1938-May 1943

Diagnosis Class	Days Per Case		
	Disabled—No Bed Disability	Disabled and Bed Disability	
		Disabled Days	Bed Days
Total	70.1	74.5	35.2
Heart Disease	80.9	102.8	28.2
Rheumatic Fever	162.5	154.3	132.5
Diabetes	117.1	95.0	19.3
Neoplasm (Malignant)	47.7	47.7	13.5
Peptic Ulcer	124.0	45.5	24.0
Toxic Goiter	16.0	31.0	31.0
All Other Causes[1]	57.0	40.7	8.7

[1] Includes crippling conditions.

tain disease categories. The cases are subdivided into those who had bed disability and those who did not. The greatest amount of post-hospital disability was suffered by persons who had accidental injuries. Cases with bed illness after hospital discharge were present in every sickness category. The mean post-hospital bed days per case ranged from 25 for accidental injuries to 3 for minor respiratory illness.

Hospitalization may be considered as one indication of severity of illness. This point may be illustrated by a comparison of the disabling days per disabling illness for all such cases with those hospitalized. There were 11 disabled days per disabled case of acute illness; those hospitalized and with disability after discharge had 29 disabled days per case, including the period of hospital care.

Chronic Illness. Twenty-one percent of the 431 hospitalized cases of chronic illness died in the hospital; 17 percent were not disabled after discharge; 41 percent were disabled but had no bed disability; and 21 percent had bed disability.

Table 4 shows the disabled days and bed days per disabled case for certain of these chronic illnesses after discharge from the hospital. Convalescence after hospitalization because of chronic disease involved a much longer period of time than was true of acute illness. With the exception of toxic goiter, chronic illness caused considerably more than a month's disability after discharge from the hospital. The outstanding disabling diseases were rheumatic fever, peptic ulcer, diabetes, and heart disease. Cases of rheumatic fever had the greatest amount of bed disability.

Provision for Convalescent Care

Convalescent care of the hospital case after discharge may present problems in the home. It is usually assumed that the housewife is responsible for such care unless the economic status of the family makes possible paid assistance of a person skilled in convalescent care. In the study in the Eastern Health District, it was possible to classify the families with convalescent patients according to their family resources for care of them. The families have been classed as to whether the housewife was the patient. If she was not the patient it was important to know whether she was disabled by some chronic condition and if disabled whether there were other persons in the home who could assist in the care of a convalescent patient. If the housewife was the convalescent patient it was important to know what assistance she had in the home. In some instances, assistance was given by adult relatives who came into the home temporarily for that purpose; in others, she was dependent upon one or more young children aged thirteen to sixteen years; in still others there were, in addition to the employed members, only very young children in the home. Patients living alone, those elderly, and families with paid assistance are also shown.

Acute Illness. Table 5 shows the provision for convalescent care at home for hospitalized cases of acute illness discharged as disabled. The data are shown separately for illness due to female genital and puerperal diagnoses and "all other acute illnesses." In 81 percent of the families where the convalescent patient was hospitalized because of female genital or puerperal illness, the patient was the housewife. Assistance in care after hospitalization was obtained from adult relatives outside the home in only 8 percent of the families. In 46 percent, all other adults in the family were employed and there were young children in the home. In only 1 percent of the families was there employed assistance or any other type of assistance from others than family members.

The housewife was the patient in relatively few of the cases of "other acute illnesses," namely, 16 percent. In most instances the housewife was not the patient and not disabled, so presumably she was capable of rendering the needed convalescent care.

Chronic Illness. Table 6 shows the resources for convalescent care at home for patients with chronic disease who were disabled on discharge after a period of hospitalization. The housewife was the patient in only 22 per-

TABLE 5. Provision for convalescent care for hospitalized cases of *acute* illness, disabled at time of discharge from hospital, Eastern Health District of Baltimore, June 1938-May 1943

Provision for Convalescent Care at Home	Female Genital and Puerperal Illness	All Other Illness	Female Genital and Puerperal Illness	All Other Illness
	Percent		Number of Cases	
Total Cases	100.0	100.0	252	619
Housewife not the Patient				
Housewife in Home				
Not Disabled	17.5	79.0	44	489
Disabled (Other Assistance in Home)	0	1.2	0	7
Disabled (No Assistance in Home)	0.4	2.4	1	15
Housewife is Patient				
Assistance from Adult Relative Who Came Into Home	7.5	2.1	19	13
Assistance Child Aged 13-16 Years	15.5	3.4	39	21
All Other Family Members Employed	11.9	6.1	30	38
All Adults Employed, Young Children in the Home	45.6	4.5	115	28
Patient Lives Alone	0.4	0.6	1	4
Patient Elderly				
Only Other Person Also Elderly, 65 Years or Older	0	0.5	0	3
Employed Assistant	1.2	0.2	3	1

TABLE 6. Provision for convalescent care for hospitalized cases of major *chronic* illness, disabled at time of discharge from hospital, Eastern Health District of Baltimore, June 1938-May 1943

Provision for Convalescent Care at Home	Major Chronic Illness[1]	
	Percent	Number
Total Cases	100.0	161
Housewife not the Patient		
Housewife in Home		
Not Disabled	66.5	107
Disabled (Other Assistance in Home)	0.6	1
Disabled (No Assistance in Home)	6.8	11
Housewife is Patient		
Assistance from Adult Relative Who Came into Home	1.9	3
Assistance Child 13-16 Years of Age	3.7	6
All Other Members Employed	16.2	26
All Employed, Young Children in Home	0.6	1
Patient Lives Alone	1.2	2
Patient Elderly		
Only Other Person Also Elderly, 65 Years or Older	2.5	4
Employed Assistant	0	0

[1] Includes crippling conditions.

cent of the families; she was not the patient but was disabled in 7 percent. Consequently, in 29 percent there may have been need for some extra assistance in the home.

These data of acute and chronic illness disabled after hospitalization present for the first time the family situation with regard to its own resources for provision of convalescent care. The aim of preventive medical care and public health is to shorten or eliminate the period of disability due to illness. Hospitalized illnesses have been shown to illustrate the need for consideration of the problem of convalescent care in the home.

The data presented here suggest also that study of the problem is needed. For example, only 16 percent of the nonhospitalized pneumonia cases and 30 percent of the home deliveries had some form of nursing care, that is, care from a fulltime bedside nurse or a public health nurse. This indicates a relatively low level of utilization of nursing service where such service would seem most appropriate.

Acknowledgments are made to the Departments of Biostatistics and Epidemiology of the Johns Hopkins School of Hygiene and Public Health and to the Baltimore City Health Department for generous assistance and cooperation which greatly facilitated the carrying on of the study of illness in the Eastern Health District of Baltimore.

Especial acknowledgments are made to Dr. Selwyn D. Collins and to Miss F. Ruth Phillips, who participated in all phases of the Baltimore Morbidity Survey.

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Sociodrama: A Way Of Teaching Mental Health Skills

The authors describe their use of one form of group experience, the sociodrama, to help nurses develop interview skills

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SKILL IN WORKING with people is one of the basic factors in any professional relationship. Acquiring this skill is not a simple matter. It requires an understanding of one's own characteristic feelings toward others and the development of conscious ability to manage these feelings. Beyond this, it requires practice in the art of building relationships and in the use of self in a supportive way with people. Through the use of group participation technics our effectiveness in teaching these skills to nurses has been considerably increased.

Learning in the field of human relations not only requires intellectual grasp of content and theory but also growth in attitudes and feelings. In recent years a great deal of work has been done to discover ways and means of getting more effective learning and greater student participation in inservice training. Many of the older and more familiar technics in use are timeconsuming and lack the dynamic force to effect any emotional reeducation. Recently the use of group experience, especially the sociodrama, has demonstrated the possibilities of these technics not only for giving teaching content but also for providing experiences which give one the actual "feel" of life situations. Such "experience education" seems to help participants gain a deeper emotional and social understanding, an understanding that is a part of one's self—that is felt with the "bones and muscles" as well as experienced in thought. Over the past year and a half we have been using these new educational tools experimentally to help nurses more adequately meet the human relationship problems they face in their daily work.

For example, nurses are frequently confronted with patients who cannot accept a diagnosis or follow a plan of treatment. The patient may be so upset and confused he cannot think clearly. He may actually resent his sickness so much that he unreasonably turns his resentment against the nurse, making her a symbol of the illness which he cannot accept. In reality, the *feelings* that the patient has built about his illness can become as incapacitating as the illness itself. When a nurse does not understand this emotional side of a problem she can become so frustrated by an uncooperative patient that her own personal feelings may interfere with her ability to be helpful. When this happens the nurse then has two emotional problems to deal with (1) handling her own feelings about a patient who frustrates her and (2) helping the patient handle how he feels about his sickness. Until these emotional problems are faced the nurse's primary job in helping the patient accept the

diagnosis and secure treatment is usually blocked or retarded.

Working from the premise that skill in human relations must come from experiences in which the nurse arrives at both intellectual and emotional understandings, we have used sociodrama in several types of inservice training experiences with nurses in the public health field. We have usually worked with groups of from twenty to twenty-five nurses for periods varying from a day to three days.

In order to develop maximum communication between participants they are seated in a circle. We believe this facilitates learning because it helps each individual determine how well other members of the group are accepting content and ideas that closely resemble or differ from her own. We have found that nonverbal communication, which consists of nodding, smiling, shaking the head, and other forms of si'ent expression, is one of the most important factors in helping individuals share the group experience. In preparing the group for this kind of experience it is important that the members get to know one another as individuals. We try to help the group develop the feeling that within this experience all are equal, and that professional title, position, and status are not important. To help accomplish this each group member takes three minutes to get acquainted with the individual on her right, then introduces her by her first name to the rest of the group, telling only those things which will enable the others to see the person instead of the professional self.

At this point two or three people may be selected on a volunteer basis to talk about the feelings they might have if suddenly faced with a serious illness, for example, cancer, tuberculosis, or arteriosclerosis. As a matter of fact, this is a preliminary sociodrama. As these people present their ideas of the problems that would be faced and of the feelings they would have about them the group seems to identify with them and frequently begins to suggest many other types of feelings or problems that these individuals might possess. This demonstration and similar kinds of experiences with the group help them to feel as the patient does. Its greater value, however, seems to be in involving the personal feelings of the group, so that the discussion grows out of real feelings rather than intellectual concepts. The larger group is then broken up into three or four groups of from six to ten people who select through discussion real cases from their experience which they want to submit for group study. These case situations, as they are reported back to the larger group, provide the material for the sociodramas.

The sociodramas are brief scenes acted out by two or more people, usually centering around a conflict situation. Since the actual situations or content come from the work experiences of the group, the presentations are always oriented to genuine needs of the group. The technic seems to be most effective when the leaders fundamentally believe in the capacity of the group members to solve the problems presented. They should see their leadership role as servants of a group, providing methods by which the group can define and study its own problems.

Maximum learning seems to take place when the leader, with a warm and accepting tone, helps the group members to use their own successes and failures in the sociodramas to broaden their understanding and to discover new and more effective ways of dealing with human relationship problems. In our experience a warm accepting manner on the part of the leader seems to help group members feel secure enough to participate freely. Soon after the experience is started the people in the group tend to adopt the leader's attitudes and begin to show more acceptance toward one another. This produces a freedom of expression not found in formal types of group learning. Out of this kind of emotional climate usually come genuine group thinking and a desire to be more sensitive to and understanding of people. This desire becomes the motivation for learning the skills necessary to an understanding way of working with people.

Let us look briefly at a typical nursing problem and see how it was worked out in sociodrama. Here is the problem as presented

by a group of nurses studying tuberculosis control. This is a man thirty-three years old, with a wife and two children. The income level is low. The man's tuberculosis was detected through a health department survey. He has had three x-rays showing active tuberculosis, and is sputum positive. He has been told of his diagnosis by the health officer. However, he refuses to accept it. He is anxious, fearful, and belligerent. He is worried about his family and its ability to survive financially. He fears he may die if he goes to the hospital. Since he has refused to accept the diagnosis of tuberculosis the public health nurse has been given the assignment of visiting the home to help him come to a realization of the problem and accept treatment.

One person selected by the group to be the "patient" was taken aside by the leader, privately briefed on the general setting, and helped to develop the "lines" that such a patient would normally use. She was asked to try not to give in to the "nurse" and to maintain the role of the anxious, belligerent man who refuses to accept the diagnosis.

Meanwhile in the circle another staff leader prepared a group member who had been selected to be the "helping person." (The whole group shares in this planning and understands it is to help in the solution of this problem.) This preparation was done by telling the "helping person" that for the time being she was to imagine herself the patient. She was then asked "If you suddenly discovered that you had tuberculosis, what would happen to your life plans? What would be your concerns about your family? What kind of financial plans would you have to make? How would you feel about going to the hospital?"

Consideration of these questions helped the group and the "helping person" identify with the patient, enabling them to experience some of the thoughts and feelings that the patient might have. Thus sensitized to the problem the "helping person" was asked to adopt the role of tuberculosis nurse and was questioned about how she felt about working with this kind of a person, knowing how he might be feeling. Then, by discussion, the group explored the problems of sympathy, over-identification, resentment, and other ways of getting one's own emotional feelings so involved that they might distort the real picture of the patient and his problem. The group was also encouraged to suggest ways and means by which this nurse might tackle the problem the patient would present.

The patient was then brought into the room and the interview began. As is usual in first experiences the nurse talked to the patient about the problem of tuberculosis and the need to go to the hospital. On the other hand, the patient stolidly maintained that he didn't have tuberculosis, that he didn't want to go to the hospital, and began to question the veracity of the diagnosis and the competence of the nurse, the doctor, and the whole health department staff. Confronted by this continuous frustration the nurse's feelings were aroused and, without realizing it, she became defensive, argued, cajoled, and even tried the pressure of law as a means of getting the patient into doing what the nurse expected him to do. At this point the sociodrama was interrupted and the group discussed what had actually taken place.

With the leader's help the group began to recognize that the patient had managed to trap the nurse into talking about tuberculosis and hospitalization, which kept her from helping him to face those personal feelings about his tuberculosis that were blocking him from taking any positive action. Through discussion it became possible for the group and for the person playing the role of the nurse to see how the nurse's feelings got in the way. More than this, one might say that everyone actually experienced what happened when the nurse's advice-giving failed and she tried to high-pressure the patient into accepting his tuberculosis and the needed care.

The group members also began to realize that they had not seen the patient as a person —they had seen only his illness and need for treatment. They saw that the patient had no real feeling that he was understood, or that his *right* to feel resentful, anxious, and fearful was really accepted. The group was then given an opportunity to suggest new lines to the nurse, and the scene was begun again. This time the "nurse" did a better job of con-

trolling her feelings, until the "patient" became extremely obstinate and stubborn. Again the nurse's feelings trapped her into trying to control the patient by giving advice. When the nurse—and the group members identifying with her role—recognized this they began to get a real feeling about what happens in their own work interviews.

AFTER A NUMBER of suggested approaches were tried out the group, with the help of the leader, began to try to develop principles for use in interviewing and to formulate approaches which might be more effective. From these discussions two general principles began to emerge: (1) If you are to work effectively with a patient, it is important to recognize your own feelings and be able to control them, and (2) it is important to recognize the feelings of the patient and let him know that you do. The group then tested these principles by trying them out in the sociodramas. In order to facilitate this testing and learning the leader stood beside the "helping person" to guide her and the group in identifying and responding to the underlying feelings presented by the patient. Gradually, through practice, these principles became meaningful and group members began to develop skill in using them.

The group began to discover that use of this approach built up a relationship to the patient which enabled him to trust the nurse and feel understood. This process became another interviewing principle which was described by a leader as "building the bridge of relationship." It should be borne in mind that all of these patterns and principles evolved out of the actual experience that was taking place within the sociodrama.

After this sociodrama was worked through, two more problems were used to give practice to other group members. Recognizing the other person's feelings and helping him sense that you understand and can accept them seemed to be the hardest principle for the group to put into action. To help the group with this problem the leader introduced two study technics designed to explore how feelings are communicated.

First, the group studied nonverbal communication of feelings. This was done by having a staff member walk into the room as if he were portraying a defiant, antagonistic, stubborn patient, trying to express all this by using body forms of expression only, without saying a word. The group was then asked to say what this patient had "said." This brought forth a range of comments, most of which correctly interpreted the feelings the patient intended to portray. The second time the staff member silently portrayed an anxious, fearful, worried, upset patient. The group again was able to identify this patient's feelings. The same method was then used to study how the "helping person's" attitudes and feelings about the patient were communicated to the patient nonverbally. These experiences led to discussion of how the "helping person's" manner of walk, position of sitting, use of hands, and facial expression could be used to communicate a sincere desire to help the patient.

Then, in order to help the group develop verbal skills in communicating an understanding of the patient's feelings, one of the leaders sat in the middle of the circle and played the role of a person who is anxious and fearful. He began to talk about his problem. The group was asked to respond to him in such a way that this leader would feel more at ease, accepted and liked—so that he would sense that the group supported him and wanted to understand him. Numerous members of the group tried different approaches, and the leader maintained his role until someone correctly interpreted how he felt and expressed that knowledge to him. Two or three different types of character traits or types of feelings were presented to the group. When the group began to understand how to recognize and verbalize another's feelings and how to give emotional support, this teaching method was discontinued and the learnings were practiced in sociodramas.

THE ABOVE experience took the major part of a day of intensive work. Using these technics we have found it easy to obtain a high degree of general group participation. We feel that learning grows primarily out of the experience itself, that new concepts and new

(Continued on page 495)

Workshop on Public Health Nursing Field Instruction

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CALIFORNIA'S second workshop on public health nursing field instruction was held January 30-February 2, 1951, at the Asilomar Conference Grounds in Pacific Grove, since those who attended the first conference (see PUBLIC HEALTH NURSING, October and November 1950) asked to have another meeting between the fall and spring semesters of the 1950-51 academic year to consider field training problems further. The help of planning committees in the northern and southern parts of the state was again enlisted. One hundred five people participated, including a psychiatric social worker, a stenographer, six young women who had just completed programs of study in public health nursing, and ninety-seven experienced public health nurses, the majority of whom were serving as student advisers or were in supervisory positions.

The opening session was lively. After a brief orientation lists of agree-disagree statements on field instruction were distributed and groups, each of about ten people, conferred on four or five of the statements. The small groups then reported to the entire group on whether they agreed or disagreed with the statements, commented on the reasons for their decisions, and in some cases indicated rephrasing which they wished to adopt. The statements purposely dealt with controversial points and the discussion which was provoked carried over to the work group sessions.

After lunch people joined their previously designated work groups and worked there until the final day of the conference, when the entire group came together to receive reports and to hold a concluding discussion. A number of the work groups started their study at the point where work groups had concluded in the 1950 conference.

The work group on the evaluation of student performance presented a statement of standards which a student might be expected to meet at midterm and at the close of her period of field instruction. The standards were in relation to the student's organization and planning of her work, professional skills, and personal factors. Those who considered what aspects of public health nursing program of study could best be taught on the campus and which in the field agency became more concerned with questions on how the campus and field aspects of the curriculum could be integrated rather than with the problem as originally stated. One work group thought through and outlined the responsibilities of the public health nursing director, the educational director, the supervisor, the field adviser, other staff nurses, and other agency personnel in relation to the student program. Two categories of responsibilities for each position were outlined: those which are direct responsibilities and those which are shared responsibilities.

Having accepted the philosophy that a public health nurse is a necessary adjunct to any clinic, and believing that agencies tend to overlook opportunities for students to have clinic experience, a work group studied this problem and submitted recommendations. Their recommendations should be helpful to all California field agencies faced with questions on the planning of clinic experience for students. The report of another group dealt

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with the kinds of student and field adviser conferences which are essential throughout the field instruction course.

IN SEEKING AN ANSWER to the question of what comprises an adequate caseload for the student a work group outlined the factors which should be considered in case selection. After studying the problem of what constitutes a desirable orientation program in the field instruction period, another group formulated a statement of the essentials of the orientation program with suggested methods of implementation.

A report which touched off a particularly stimulating discussion came from the nurses who had worked on the topic, "How Can Working Relationships Be Established and Maintained to the Advantage and Satisfaction of Both Student Adviser and Field Student?" This group discussed the possibility that the supervised home visit has serious limitations and may even create barriers to the student's growth. The group recommended that agencies explore the use of process recording and planned conferences as a substitute for supervised home visits. The term "process recording" as used by the group means a verbatim account of a visit for the purpose of bringing out the interplay of feeling between the nurse and the patient in relation to the objectives of the visit. Because of the time-consuming aspects of process recording, it was suggested that this be limited to a few selected cases or that students be helped to make a process recording of their visits to only one case during their field course.

Although the suggestion that public health nursing students be given the experience of using process recording did not meet with unanimous approval several field agencies were interested in having their students try it and two agencies made use of it during the 1951 spring semester.

Comments received from nurses who have used the reports of the 1950 and 1951 workshops on field instruction indicate that the material has been widely used as a guide in planning student programs and indirectly has had a favorable influence on the supervision of nursing staffs.

Sociodrama

(Continued from page 493)

attitudes emerge as the group members feel and think together. We find that the group is able to explore and experience the feelings behind patients' problems, and then move on to learn the practical skills of interviewing a patient who has these feelings. Instead of theorizing, different approaches are tested in realistic situations. Instead of secondhand learning, the sociodrama provides actual experience in handling interviews. Some of the nurses have reported to us in follow-up visits that this type of experience has been genuinely helpful and actually tailored to meet their own problems. They say: "I have a different feeling about my patients" . . . "The skills I learned really work" . . . "I'm succeeding where I failed before" . . . "I should have had this kind of training before I went on the job."

It should be stressed that this is a *way of teaching*, not a panacea for solving problems, or a way of manipulating people. Without sincerity this approach loses the essential quality of real helpfulness so necessary to good interviewing and good nursing. Basically, this is a method of study, a beginning experience in the art of good human relations.

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Planning the Low Sodium Diet

ANN REIMER

THE USEFULNESS OF a low sodium diet as an aid in the treatment of some diseases has been demonstrated many times. In order to understand the significance of a diet restricted in sodium, it seems advisable to review briefly some of the important functions of sodium in the living organism.

A healthy adult individual has approximately fifty liters of water in which organic and inorganic substances are dissolved. The organism is so arranged that approximately 70 percent of this water is present in the cells, while the remaining 30 percent is in the fluid surrounding the cells and in the blood.[1] Sodium is one of the inorganic elements and is chiefly present in the fluid outside the cells in a concentration approximately fifteen times that within the cells. It has a useful function in controlling the volume of body water; it exerts an osmotic pressure which aids in maintaining proper distribution of body water; and it enters into many buffer reaction mechanisms. The kidneys are the organs that help regulate the amount of sodium present in the body. Whenever large amounts of sodium are eaten, that which is in excess of body needs is excreted in the urine. When small amounts are ingested the kidneys function in such a manner as to reabsorb the amount needed, and this results in a very small quantity excreted in the urine. This regulatory mechanism of the kidneys is frequently disturbed when renal disease is present.

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A diet markedly restricted in sodium is frequently employed in certain diseases where edema is present, such as nephritis, cirrhosis of the liver, and cardiac failure. Edema is an abnormal increase in the amount of fluid that surrounds the cells. Conditions that bring about this abnormal accumulation of fluid are intricate and varied and will not be discussed in this paper. It is known, however, that in order to accumulate this additional fluid between the cells, sodium has to be present in it, since it is one of the components of this body water. Edema will not form unless both sodium and water are available.[2] Dietary management by restricting sodium is based on this concept.

The degree of sodium restriction is the responsibility of the physician and he usually bases the restriction on the minimal sodium losses from the body. In order to achieve maximum effectiveness the amount of sodium ingested should not exceed the total body losses. Sodium losses other than the amount lost in the urine are from the skin and feces—approximately 125 mg of sodium every twenty-four hours.[3,4]

Constructing the low sodium diet

The first and important step to remember in planning a low sodium diet is that this diet differs from the normal diet only in that it is low in sodium. Therefore, a diet plan which will conform to the outline of the "basic seven foods" recommended by the National

Research Council which insures adequacy of the normal diet can be applied here to provide sufficient amounts of all nutrients other than sodium in the plan. Calories can be adjusted to meet the needs of each individual by the addition of those foods which contain negligible amounts of sodium, such as sweets, unsalted fats, and cereals.

The second step, since the main objective is to plan a diet restricted in sodium, is to become familiar with the sources of sodium in foods. Although various amounts of sodium are present in almost all foods, only a few natural foods are high in sodium. The most important of these are meat, fish, fowl, eggs, and milk. Even these foods are not excluded in the plan but care is required in stressing the amount allowed. Vegetables as a class contain more sodium than fruits and a few of the former are surprisingly high in sodium. Among these are spinach, celery, beet greens, chard, and beets. These vegetables must be restricted on a diet plan requiring marked reduction in sodium. All other natural foods contain such small amounts of sodium that they need not be limited.

It is obvious that foods prepared with table salt, baking powder, and baking soda cannot be included in the diet plan. This would eliminate the use of many commercially pro-

TABLE 1. Low sodium foods (approximately 200 mg daily.)*

Food Groups	Foods Allowed			Quantity
Meat or Alternate	Any fresh meat, except kidney Any fowl Any fresh fish Oysters Egg (limit to one)			5 Ounces cooked
Vegetables (fresh, frozen or canned without salt)	Asparagus Beans, all Broccoli Brussels sprouts Cabbage Carrots Cauliflower	Corn Cucumbers Eggplant Endive Lentils Lettuce Mushrooms	Onions Parsley Parsnips Peas, fresh Rutabagas Squash Tomatoes	1 cup
Potato or Alternate	Macaroni Spaghetti Rice			As desired
Bread, unsalted	Yeast bread or rolls, made without salt or milk			As desired
Cereal	Any cooked without salt Puffed wheat Puffed rice Shredded wheat			As desired
Fruit	Any fruit (limit cantaloupe and figs to one serving)			As desired
Soups	Cream soups, made from allowed foods			
Desserts	Made from allowed foods, such as unsalted fruit pie, fruit tapioca, cornstarch pudding			
Sweets	Jam, jelly, honey, maple syrup, white sugar			As desired
Fat	Any unsalted fat			As desired
Seasoning	Spices, herbs, vinegar, vanilla, garlic			As desired
Beverage	Low sodium milk (2 cups)** Tea Coffee		Fruit Juice Coca Cola	As desired

* See references 7 and 8.

** "Lonalac" manufactured by Mead Johnson & Company.

NOTE: No salt, soda, or baking powder is to be used in the preparation of any food. No meat juices, broth, or gravies are to be included. Frozen lima beans and peas are salted.

TABLE 2. Nutritional evaluation for low sodium diet*

Daily Food Intake	Quantity		Minerals			Vitamins					Foodstuffs			
	Wt (gm)	Approximate Measure	Na (mg)	Ca (gm)	Fe (mg)	A (I.U.)	Ascorbic Acid (mg)	Thiamine (mg)	Riboflavin (mg)	Niacin (mg)	Protein (gm)	Fat (gm)	CHO (gm)	Calories[4]
Reconstituted low sodium milk[1]	480	2 cups	5.0	0.7	—	—	—	0.2	0.5	0.3	17	18	24	326
Egg	50	1 medium	40.0	0.03	1.4	495	—	0.1	0.2	—	7	5	—	73
Meat, fowl, or fish (cooked)[2]	120	4 oz. cooked	70.0	0.17	2.6	—	—	0.26	0.22	6.2	34	16	—	280
Bread, unsalted[3]	90	3 slices	6.3	0.14	0.9	72	—	0.06	0.60	0.7	6	6	40	238
Cereal, unsalted	20	½ cup, cooked	1.0	0.01	0.6	—	—	0.06	0.04	0.6	2	1	15	77
Potato	100	1 small	0.8	0.01	0.7	35	8	0.08	0.03	1.0	2	—	19	84
Unsalted vegetable, yellow or green	100	1 serving	10.0	0.10	1.4	4870	23	0.05	0.17	0.6	2	—	7	36
Unsalted vegetable, others	100	1 serving	7.0	0.03	0.4	270	5	0.04	0.03	0.3	2	—	7	36
Fruit, citrus	100	1 serving	0.3	0.02	0.4	180	42	0.07	0.03	0.2	—	—	10	40
Fruit, others	200	2 servings	5.0	0.04	1.2	522	10	0.09	0.10	0.8	—	—	30	120
Butter, unsalted	30	2 tablespoons	—	—	—	990	—	—	—	—	—	24	—	216
		Totals	145	1.25	9.6	7234	88	1.01	1.9	10.7	72	70	152	1526

[1] "Lonalac"
[2] Figures based on the use of beef 3 times, pork 2 times, and fish 1 time a week
[3] Figures for bread are calculated for bread recipes
[4] Calories can be increased by the use of sweets, unsalted fats, and cereals
* References 8 and 9

cessed foods, because it is a common practice to use sodium salts freely as leavening agents, to enhance food flavors, for bleaching purposes, as preservatives, et cetera.

As a result of the new knowledge and interest in low sodium diets several new and acceptable low sodium preparations are now available which aid in planning diets and also add interest for the patient. Now in the market are specially canned unsalted meat and fish, unsalted canned vegetables, and low sodium milk.* Many bakeries now make low sodium breads and cookies, and there are several low sodium cookbooks which aid greatly in helping the patient plan interesting meals.[5,6] It is advisable to select foods as near their natural state as possible. This lessens possible errors and also makes diet planning easier for the patient and family to understand. Table 1 is a list of low sodium foods. Table 2 presents the nutritive evaluation of the foods on the list.

Zest for the low sodium diet

To most individuals sodium restriction means marked limitations in eating and thus interference with a basic pleasure of life. The use of various seasonings aids in overcoming the lack of flavor due to the absence of salt. The following suggestions have been found helpful.

Seasonings

Horseradish

Grate a fresh horseradish root and add vinegar and pepper.

(Continued on page 505)

* "Lonalac" manufactured by Mead Johnson & Co.

Cancer Education in the Basic Nursing Program

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WE HAVE JUST PASSED the halfway mark in the twentieth century. The past fifty years represent a most important era in the development of nursing as a profession and also one in which great advances have been made in the conquest of cancer. Haven Emerson has said that when that time comes when we shall have the full answer to the causes of cancer, and the mystery of malignancy has been solved, that era will not be greater than the present era, during which so much has been accomplished in medical science in regard to early detection and methods of treatment of cancer. From the standpoint of nursing and cancer we live in a time of great hope and promise.

Today all educational institutions are being challenged to educate workers so that they may be equipped with the professional knowledge and technical skills that will enable them to take their place as leaders in their communities, ready and alert to join their efforts with others in allied fields in order to cope intelligently and efficiently with the serious problems of the day. In keeping with the current social trends it is the objective of an increasing number of schools of nursing to prepare students who will be able to give skilled nursing care, who will be community-minded, and who will be ready to serve efficiently as members of the staff of a community health agency, the hospital, the visiting nurse association, the city or rural health department. It is quite essential, therefore, for the school of nursing to work closely with the health and social agencies of the community, for its educational program must be geared to meet the needs of the health agencies and their expectations of a beginning staff nurse.

Because cancer is a foremost problem in every community, cancer education is an important phase of nursing education. What are the skills and knowledge with which the nurse must be equipped in order to function adequately in a community cancer program? When and where should cancer education be introduced into the basic curriculum?

First, we must recognize the fact that there is still a great deal of misinformation concerning cancer, which may be due to fears, superstitions, or lack of knowledge. Students who enter schools of nursing may come from homes where they were exposed to unfavorable and biased attitudes about cancer as a disease and about its prognosis. For this reason it seems desirable that cancer education should receive early consideration in the student's educational program. At Marquette University cancer education begins when the student enters the College of Nursing. Shortly after admittance she reports at the Health Service,

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where she is given a complete physical examination. Every phase of the examination, including a careful breast examination, is explained to her. The physician looks particularly for any unusual warts or moles which may become precancerous. Every effort is made to make the health appraisal a worthwhile learning experience in personal health.

The student comes in contact with the problem of cancer in all four clinical areas. The method of approach used in surgical nursing illustrates also the integration of the social and health aspects in cancer nursing. Before students are assigned to surgical nursing in the junior year they have had the course in pathology, and so come equipped with basic knowledge concerning cell structure and the abnormalities which result from pathological changes.

DURING THE PAST YEAR a new method of teaching cancer nursing was introduced. Instead of having a series of lectures on surgical conditions the students first made a survey of the patients on the surgical ward to gain an overall view of the patients: What type of surgery had been performed? How many had gastrointestinal conditions? How many had had a diagnosis of cancer? The results of this survey were compared with the results of a five-year study made in the Record Room of the hospital as to the number of patients who had had surgery for cancer. It was found in both the student survey and the five-year study that cancer of the rectum and sigmoid was responsible for the largest percentage of cases in the department. This initial project brought the students face to face with the fact that cancer is a big problem in the hospital, and would be in all their nursing activities.

Inasmuch as the students were already interested in the study of cancer of the rectum and sigmoid they preferred to continue with this phase, rather than start with a study of cancer of the esophagus, of the stomach, and of the intestinal tract, as had been done previously. Instead of the traditional classroom lessons the students, their chairman, and the instructors held informal circle discussions.

The students were given a topical outline as a guide for study. In order to become better acquainted with the patient's background each student secured a map and ascertained what parts of the city the patients came from. Other social factors of interest followed naturally: What were the reactions of the members of the family to the disease? Did the patient have insurance to help him with the hospital bill? Did the patient fear to see his doctor? Was this the first hospital experience for the patient? What diagnostic procedures did he undergo before entering the hospital? Could the cancer have been prevented?

Two patients with diagnosis of cancer of the sigmoid were selected for comprehensive study. Patient No. 1, who consulted his physician late when the disease was in an advanced state, had a colostomy performed. He went through a difficult adjustment and had considerable mental anguish. Patient No. 2 had been diagnosed during a routine physical examination, followed by x-ray and other diagnostic procedures. A colon resection was done and in a short time he was able to return to his home, the wound healed, no dressings needed, and the prognosis favorable for permanent cure. Patient No. 1 returned home in a much less happy frame of mind, still needing dressings, constant medical supervision, and much rehabilitation.

BECAUSE OF THE DIFFERENCE in the needs of these two patients various comparisons were made: The difference in costs of care between early and late diagnosis, as well as in the welfare and general happiness of the patient and his family. The students discovered, too, that the approach to teaching in the early and late case differs considerably. The students found that patients with advanced cancer depended heavily on them for moral support and, because of this, preferred to have the same nurse provide the nursing care. As the nurse helped the patient face the crisis in his life with equanimity of spirit, unconsciously she took stock of her own inner spiritual resources and her philosophy of life.

Some time during the discussions the physician joined the group in order to interpret his preoperative care of the patient, the ques-

tions the patient asked of him, as well as the patient's reaction and that of his family to the diagnosis. The surgeon or resident physician discussed the anesthetic that was used and the patient's condition during surgery. If a transfusion had been given the discussion included information about the blood bank. The nutritionist discussed diet therapy of the particular patients being considered. Other points which naturally came up were the medications used and the rehabilitation procedures, as well as the question as to whether the patient would need community help on returning to his home, and what resources were available to him.

With every referral of a cancer patient the student gained a better appreciation of the functions of community social and health agencies as she was able to relate the services to the care of the patient. An interagency referral slip, developed by local public health nursing agencies as a result of a joint project in the care of the polio patient, was available also for referral of the patient with cancer.

The value of the periodic health examination having been shown to the students, their interest in the prevention of cancer was stimulated. At this time, or in the unit in gynecology, the student made a visit to the Cancer Detection Center. Here she observed the coordinated effort of physicians, medical students, and nurses, all seeking to help the patient who came with his fears and problems. Here the student observed procedures not ordinarily carried out in the hospital, such as the vaginal examination as a diagnostic aid, and the cytologic test.

Educational films on cancer and its early diagnosis were secured from the local cancer society and from the film library of the state board of health. These were supplemented by available literature. Students found the leaflet, *Building the Morale of the Cancer Patient* especially helpful, as well as articles on cancer which have appeared in our professional literature.

Early in their professional preparation students become acquainted with PUBLIC HEALTH NURSING, which has made a monthly appearance in the library of the College of Nursing for many years. In the revision of course outlines and in the preparation of reference material on cancer nursing, the magazine has proved most helpful to clinical instructors and students alike. Of particular significance and interest have been the articles, Teamwork in the Home Care of the Cancer Patient, September 1950, and The Cancer Patient as a Person—His Needs and Problems, by Eleanor E. Cockerill, February 1948.

In analysis, this new method of teaching cancer nursing has had good results. Patient-centered care results in improved service to the patient. The nurse, too, is benefited, as she gives complete care to the cancer patient. She finds herself growing in personal and professional maturity, and developing that most important asset in nursing, a real liking for and an interest in people.

The Power of Statistics

MILDRED E. NEWTON, R.N., Ed.D.

SOME PEOPLE consider statistics deadly dull, a subject to be shunned in a curriculum or a section to be skipped in an article. Others take a different attitude and recognize that statistics can be both stimulating and potentially powerful. Florence Nightingale belongs to the latter group who find in statistics a power and a weapon.

One question haunted Miss Nightingale upon her return from the Crimea in 1856: "Must what has here occurred occur again?" She had watched thousands of men sicken from avoidable causes and die in unprecedented numbers because of the apathy and ignorance of their military commanders. As she left the Crimean battlefield she had vowed, "I stand at the altar of the murdered men, and, while I live, I fight their cause."

All the weapons at her command were assembled for this fight. Her battle was against government officials armed with regulations and tradition, a public bristling at any suggestion of increased expenditures, even medical men to whom her new concepts of health and sanitation were ridiculous nonsense. In this combat she utilized her diplomatic skill and unyielding perseverance, her firsthand experience and unrefutable statistics.

Today statistics seem a matter-of-fact approach to many a problem, but in 1856 this science was in its infancy. This amazing woman without any training in biometrics or any course in demography had the insight to perceive the value of this tool. She saw its use, and her brilliant mind formulated methods of collecting, analyzing and interpreting hundreds and thousands of pages of statistical data. Without calculating machines or a skilled technical staff she forged her statistical sword.

The book which had opened Miss Nightingale's eyes to the tremendous possibilities of statistics in the health and social field was *Essai de Physique Social* by the Belgian statistician, Adolphe Quetelet. He had given her the book as a token of his esteem and admiration. A few others realized the force of figures. Among them was William Farr, England's most noted statistician and Miss Nightingale's adviser and friend.

Years later when she tried to persuade Sir Francis Galton to join her in endowing a professorship of statistics at Oxford, the objection was raised—and it was all too true—who would ever take a course in statistics?

As Miss Nightingale worked with mortality and morbidity rates, statistics from the military and civilian populations of England and India, she came to several conclusions. Her own statements expressed the conviction that statistics, the most important science in the world, (1) must be used to be useful (2) will answer questions (3) will predict the future, and (4) will measure results.

Statistics must be used

Miss Nightingale's philosophy included many tenets closely allied with modern pragmatic views. She believed that one learned by doing, that experience and mistakes were the most effective educative forces, that value was proven by use. Therefore she declared that if statistics were to be of value they must

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be used. They must aid in the establishment of preventive measures. She would not accumulate pages of figures to disintegrate in unopened files. Just as she insisted that all the Sub-Commissions to the Royal Commission on the Health of the Army be working commissions, producing and showing results, so she demanded that statistics bring about reforms. She used them to enlighten, to shame, and to prod government officials. Even beyond this, she used them as a threat. Her famous *Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army* were damning and incontestable. Every statement which she made was backed up by a phalanx of statistics and accompanied by a recommendation. But in governments wheels move slowly—very slowly. When the key men in her reform schemes would dally away days and weeks with their grouse shooting and fox hunting, she would send threatening messages after them: If they did not come back and drive her bills through, she would release even more damning statistics. Shuddering at this prospect they would return to the task of saving the lives of the British soldiers.

Two steps were deemed indispensable by Miss Nightingale in the proper use of statistics. First the men who were to govern their country must be taught the use of statistical facts. Then the press must disseminate this information. An informed public, she felt, would never allow bygones to be bygones, and never again permit half an army to be lost from disease.

Statistics will answer questions

With a curiosity as insatiable as that of the elephant's child, Miss Nightingale wanted to know why? why? Why did sixty percent of the men die of disease during the first seven months of the Crimean conflict? Why did none of the three methods of keeping mortality lists agree? One list would have a man dead and buried while another would show no such casualty. At what age were particular diseases most prevalent? What was the mortality rate for certain types of operations? No one had these answers. Her earliest move towards answering the first of these questions was to equip a dissecting room for the army medical staff at Scutari, so that they could find out why men died. From this embryonic start the Army Medical School was born.

Questions in the health field were not the only ones which Miss Nightingale wished answered. In 1891 she wrote Sir Francis Galton posing more inquiries. Millions of pounds had been spent in the preceding twenty years on the education of children. She wanted proof of (1) the proportion of children who forgot their whole education and so wasted it (2) the results in the lives of those who did not forget what they had been taught (3) the methods used by night and secondary schools which prevented primary education from being wasted and (4) the effect which education had on crime. Statistics alone would provide sound guidance for the expenditure of educational funds.

Statistics can predict

Illustrations from three different fields show the type of prediction Miss Nightingale expected from statistics. The death rate in the Line, Artillery, and Guards in peacetime was running 17, 19, and 20 per 1000 men as opposed to 11 per 1000 in the civilian population. This she called criminal, and bluntly told John Stuart Mill that they might just as well take 1,100 men out upon the Salisbury Plain and shoot them. From these facts she derived the terrible slogan which she used with telling force when reforms moved too slowly: "Our men enlist to death in the barracks."

Quetelet, whose book had stimulated Miss Nightingale so greatly, also commented upon this use of statistics for prediction. He had indicated that murder was committed with as much regularity, and bore as uniform a relation to certain known circumstances as did the movements of the tides and the rotation of the seasons.

In her *Notes on Hospitals* Miss Nightingale pressed for statistical data by which the relative value of particular operations and modes of treatment could be predicted. By such a means she believed that life could be saved, suffering reduced, and the treatment of the sick and maimed poor improved.

Statistics will measure results

Again in the fields of education, of sanitation, and of army reform, this "passionate statistician" showed how results could be measured statistically. In a letter to the Earl of Shaftesbury in 1860 she pointed out that where schools offered even half time instruction to orphaned and abandoned children, the number of these unfortunates involved in crime and vice dropped from two thirds of the group to only two percent. With great satisfaction she reported that in the houses which had been improved from a health standpoint, the mortality rate had fallen in certain instances from 25 and 24 per thousand to 14 per thousand.

Almost every biographer comments upon the relentless manner in which Florence Nightingale drove her chief agent for reform, Lord Sidney Herbert. At her insistence he had been made chairman of the Royal Commission on the Health of the Army and of all four sub-commissions established to remodel military hospitals and barracks, reorganize medical statistics, institute an Army Medical School, and reorganize the Army Medical Department. Shortly after his death she wrote a tribute to this friend without whom her reforms could never have been made effective. *Army Sanitary Administration and Its Reform Under the Late Lord Herbert,* 1862, has as its frontispiece three beautifully lettered and colored bar graphs which most effectively tell the story of the lives saved by the work of these two crusaders. (Incidentally, Miss Nightingale was one of the very first to use colored bar and pie graphs and squares to highlight her statistical findings.) These three bars show the following dramatic results:

MORTALITY RATES PER 1000 FROM

	Zymotic diseases	Chest and tuberculous disorders	All other diseases	Total
English male population Ages 15-45 (1848-54)	2.0	4.5	3.3	9.8
How Lord Herbert found the army serving at home 1837-46	4.1	10.1	3.7	17.9
How Lord Herbert left the army 1859-61	0.96	4.2	3.4	8.56

Very similar improvements were secured when the reforms recommended by this invalid lady lying in her London bedroom were put into effect in the British Army serving in India.

Recognition of ability

The actual results of Miss Nightingale's preparation, analysis, interpretation, and use of statistics are best demonstrated by such figures as those quoted above in the reduced army death rate. Her Blue Books, official reports prepared for the government on matters of health and welfare, are the greatest proof of her statistical genius. Hospital statistical forms were devised, census reports drawn up, and plans for both military and civilian hospitals revised, because of her statistical prowess. Edwin Kopf assigns her a place in the history of statistics next to those occupied by Quetelet and Farr. Her unique ability was recognized in England in 1858 when she was made a Fellow of the Royal Statistical Society. Her fame in this field spread abroad and in the United States she was elected an honorary member of the American Statistical Society in 1874.

Conclusion

Miss Nightingale herself commented frequently upon a most unusual aspect of statistics, their religious connotation. They were one of the surest means by which she discovered the thought of God. To her all natural law existed as the expression of God's plan and will, and thus statistics derived from the study of this law became the measure of His purpose. So, in this area as in all others, her religion became a motive for action.

Throughout her long life of ninety years this "passionate statistician" continued to use this powerful weapon of statistical proof in order to force issues, institute reforms, and improve the health and welfare of mankind. The results secured were her only means of avenging the men who lay so needlessly in their Crimean graves, and of assuring the world that what had happened would never again be repeated.

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Low Sodium Diet

(Continued from page 498)

Chili sauce or catsup

Use your favorite recipe, omitting salt.

Mustard

1 teaspoon dry mustard
1 teaspoon flour
1 teaspoon vinegar
water
sugar to taste

Mix dry ingredients, add water and vinegar, and bring to a boil.

Cool.

Salad dressing

Use your favorite recipe, omitting salt and sauces that contain salt. Vinegars and wines in which herbs have been steeped add zest to many salads.

Herbs and garlic

Added to vegetables and meat dishes enhance the flavor.

Interpreting the diet plan to the patient requires as much care and precision as making the plan. Since the amount of sodium allowed is usually in terms of milligrams (1/30,000 of an ounce) there is little room for error and the patient must have a clear understanding of the facts. He must understand that everything he eats and drinks, including water and medications he may take, contains some sodium which has to be added in measuring his allowance.

The patient on a low sodium diet requires a lot of help, but given proper instructions, he can learn to plan his meals, and he can enjoy them.

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Your Place in the New Structure

In 1950 the members of AAIN, ANA, ACSN, NACGN, NLNE, *and* NOPHN *expressed general endorsement of a two-organization structure. Since then a special committee on structure of each participating organization and a Joint Coordinating Committee on Structure have been developing cooperatively a plan which will be submitted to the members for their consideration and vote. These committees are following a timetable so that members will have information about the recommended plan in ample time to study it in detail. This article is the third of a series. It is based on the assumption that the members of the participating national organizations will approve of the plan developed by the national committees on structure and will take necessary action to bring the new structure into being. But it should be emphasized that the final decision will, of course, be up to the members.*

NEXT SPRING the members of the participating national nursing organizations will be asked to decide on a new structure for organized nursing. It is proposed that this have a two-organization basis: the American Nurses' Association (ANA) which in some respects will be different from the present organization, and the Nursing League of America (NLA) which will be a new organization unique in the United States, and so far as we know, in the entire world.

With some changes in its bylaws, especially in regard to sections and the House of Delegates, the ANA will be the organization for professional nurses and professional nursing students only. It will be dedicated to helping them become the best possible practitioners as individuals and as members of a profession and to watching out for their general and economic welfare. Its functions will be expanded. It will have more national sections, and we should see even greater section activity than in the past. For the first time student nurses, too, will have membership in the ANA, participating in a council of their own.

It goes without saying that all professional nurses should give support to the organization concerned with advancing their performance and standing as individual practitioners. The best way for them to do this is to continue their membership in the ANA, or, if not now members, to join as soon as possible. In this way every nurse will be able to take part in activities concerned with improving practice in his or her occupational field and in the profession as a whole.

The NLA, the second organization in the new structure, will be dedicated to furthering the development and improvement of organized nursing services and education for nursing so that, in so far as possible, the nursing needs of the people may be filled. It will be an organization both for nurses and for other citizens. These will include consumers, members of boards and committees associated with nursing services and nursing education units, and members of other professions. All of

these share responsibility with nurses for seeing that in communities up and down this land, and other lands as well, good organized nursing services and good education for nursing are provided.

All professional nurses, no matter what their occupational field or position, who are eligible to join the ANA will also be eligible and urged to join the NLA.* What is more, they will be needed just as much in one organization as in the other. Every student in an accredited school of nursing will be invited to join NLA as well as ANA. Every nonnurse in a special relationship to an organized nursing service or a nursing education unit, or who in some other way has demonstrated an interest in good nursing standards, will also be needed in the NLA. So will agencies that provide nursing services—hospitals, other institutions, health departments, visiting nurse associations, and other voluntary public health nursing agencies, schools, and industrial plants. So will schools of nursing whether they are part of a hospital, college, or university.

The New NLA

How will the new organization be formed? What will become of present organizations other than the ANA? Is it important to continue membership in them until the new Nursing League is founded? How and when can you or the service, institution, or school with which you are associated join the new organization?

According to present plans the National League of Nursing Education (NLNE) will be the nucleus for the new NLA. However, it will need to change its articles of incorporation and its bylaws in most details so that they will conform to the recommendations that the national committees on structure have made for the new Nursing League of America.

When the necessary action is taken by their respective members the American Association of Industrial Nurses (AAIN) and the National Organization for Public Health Nursing (NOPHN) will transfer some of their functions to the ANA, but most of their functions and all of their members to the NLA. The Association of Collegiate Schools of Nursing (ACSN) will transfer its entire program and all its members to the NLA. Individual, agency, and school members of AAIN, ACSN, NLNE, and NOPHN who have paid their dues for 1952 will become charter members in NLA. For the rest of 1952 they will be eligible to receive all services offered by the new NLA which, it is hoped, will include some services not previously available. Members transferred in this way will not be required to pay NLA dues until January 1953.

In addition to the members transferred from the present organizations, it is expected that NLA will have many new members, especially hospital nursing services which now are not part of any national nursing organization.

In one sense, the four national nursing organizations will be gone when the new structure comes into being. In another sense, they will continue. With new responsibilities and with their identities merged, their programs expanded and coordinated, and their ranks swelled by many new members, they will work together toward a common, broader objective.

It therefore becomes of the utmost importance for all members of each of these four organizations to renew their membership for 1952. It will also be important for a person not now a member to join at least one. By doing so, he, too, will become an NLA charter member—along with AAIN, ACSN, NLNE, and NOPHN members of long standing—and so, from the moment NLA is founded, be able to shape its program and future.

NLA charter membership for professional nurses and nonnurses

If you are a professional nurse, no matter in what occupational field you are working or what position you hold, or if you are not a nurse, you may join either NOPHN or NLNE for 1952 and then be transferred to NLA when it is organized. The present NLNE bylaws list rather specific qualifications for nurse and lay membership, but membership in NOPHN is open to any professional nurse or nonnurse interested in public health nursing. Therefore, through membership in one or both

* Membership in ANA will not be required of NLA nurse members, however.

of these organizations, charter membership in NLA is possible for all professional nurses and for all interested nonnurses.

If you are an industrial nurse you may hold membership in the AAIN for 1952 and be transferred to NLA, if AAIN members take action on the new structure before December 31, 1952. To be eligible to join and vote in AAIN you must be a graduate registered nurse who is "employed fulltime in commerce or industry and engaged in conserving the health and safety of employed workers." Or you may be a nursing consultant who devotes "fulltime to the field of industrial nursing."

Charter membership for schools of nursing, public health nursing services, and industrial nursing services

Not only individuals, but collegiate schools of nursing, public nursing services, and industrial nursing services, as well, may enjoy the distinction of being NLA charter members for part of 1952. Collegiate schools may gain NLA charter membership through 1952 membership in the ACSN, public health nursing services through 1952 membership in the NOPHN, and industrial nursing services through membership in AAIN.

Although many public health and industrial nursing services and collegiate schools of nursing will be transferred to NLA through NOPHN, AAIN, or ACSN, other kinds of schools of nursing and other organized nursing services will also be eligible to join NLA when it is organized. If they meet certain qualifications, schools of nursing—whether associated with hospitals, colleges, or universities—and hospital nursing services will be urged to join, too.

Where to Write for Information

For information on membership in the present five national nursing organizations write to the following: AAIN membership—Mrs. Gladys L. Dundore, executive secretary, AAIN, 654 Madison Avenue, New York, New York; ACSN membership—Elizabeth S. Bixler, president, ACSN, c/o Yale University School of Nursing, 310 Cedar Street, New Haven, Connecticut; ANA membership—Ella Best, executive secretary, ANA; NLNE membership—Julia M. Miller, executive director, NLNE; and NOPHN membership—Anna Fillmore, general director, NOPHN. ANA, NLNE, and NOPHN are all at 2 Park Avenue, New York 16, New York.

Summary

Many persons have worked hard and long on the details of the plan for the new structure on which members will be asked to make a decision next spring. Much thought, energy, time, and money have gone into making it the best possible plan for all concerned. You can do your part in seeing that the plan is translated into two active organizations with productive programs. Both organizations will have distinct and separate purposes and functions. Both will be able to fulfill their purposes and functions to the extent that you, other persons eligible for membership, community agencies, and schools of nursing, give full support even before the new structure comes into being.

This article appears also in the *American Journal of Nursing*, September 1951.

* The details of the recommended new structural plan for ANA and NLA will be published in early issues of the *American Journal of Nursing* and in PUBLIC HEALTH NURSING. Future articles will be devoted to these subjects: how nurses in the various specialties will participate in both the ANA and the NLA; how nonnurses, hospital nursing services, industrial nursing services, public health nursing services, and schools of nursing will participate in the NLA.

Reprints of all articles on structure will be available. NOPHN plans to buy reprints from the AJN. One reprint will be sent free to those who regularly receive "Memo to Member Agencies." The list includes all member agencies, liaison officers (representative board members of member agencies) state directors of public health nursing, SOPHN presidents and lay chairmen, directors of university programs of study, deans of accredited basic schools of nursing preparing nurses for beginning public health nursing positions, Public Health Service and Children's Bureau nursing directors and regional consultants. In addition a small supply will be available for distribution under NOPHN's regular policy for distributing reprints.

The story of the pilot study which led to the establishment of contracts for the community nursing service throughout the United States

The VA Community Nursing Program

RUTH ADDAMS, R.N.
IVA TORRENS, R.N.

SINCE NOVEMBER 1950 the Veterans Administration has entered into contracts with 402 community nursing agencies in the United States to pay on the visit basis for authorized nursing care of eligible veterans. This program was set up only after the need and value of such community service were established through a pilot study carried on from April to November 1949 in the New England area.

The increasing use of private physicians on a fee basis for home town care of veterans, eligible but unable to attend regional office clinics for treatment, brought requests for parttime home nursing services also. New England was selected because of the large number of nursing agencies available and the interest shown by the physicians, community agencies, and the personnel in the branch office of the VA. A good deal of preparatory paper work was first required. Regulations, such as agency requirements for contract and procedures for the regional office to use in arranging care, receiving reports, and paying agencies, were set up. When all was ready a team composed of representatives from the central office staff and from the branch office, the medical director, chiefs of nursing, and medical administrative divisions, visited the four VA regional offices, the six VA hospitals, and the two VA centers in the New England states to discuss the program. Meetings were also held with medical and nursing representatives from state and local health departments and from community nursing agencies. When plans were completed letters were sent to fee basis physicians by the chief medical officers of the regional offices, explaining the availability and provisions of the program. Contracts for service were solicited from 352 community agencies, and 160 contracts were finally signed.

Hospitals and regional office clinics were requested to point out problems encountered in the use of the program and to give suggestions for improvement. Only one major change in the regulations was found desirable during the course of the study. It was soon recognized that certain hospitalized veterans could benefit from parttime nursing care while on leave from VA hospitals, and therefore the regulations were broadened to include service to veterans on leave from the hospital, provided they were eligible for outpatient treatment by the VA. The medical supervision of these patients remained with the hospital physician who initiated the request for nursing care, and he received reports through the regional office.

Miss Addams is deputy director, Nursing Service, and Miss Torrens is chief, Community Nursing Division, Veterans Administration Central Office, Washington, D. C.

Before the test period had progressed far we began to receive enthusiastic reports about benefits to patients. Marion Gay was one of these. He was receiving educational benefits under Public Law 16 which entitles veterans with service-connected disabilities to vocational training. He had been attending the VA clinic for care of an unhealed gunshot wound in his right leg. The long period of hospitalization had been ended in time for him to enter the university for the fall session. He was preparing to become a teacher. Marriage was next on his list of accomplishments, and in due time a baby had been added to the family.

MR. GAY HAD BEEN taught by the regional office nurse to clean and dress his wound between clinic visits. He had been instructed about the reasons for a special diet, elevation of his leg, and the amount of rest prescribed by the clinic physician. In spite of a careful regime Mr. Gay's wound began to drain profusely. The clinic physician wished to have the wound irrigated, medication instilled daily, and no weight borne on the leg. The distance from the Gay home to the clinic made daily visits impractical, so the physician requested the clinic chief of the nursing unit to arrange for the community public health nurse to give treatment daily for a week and to assist the family in planning for Mr. Gay's care.

At the end of the week Mr. Gay returned to the clinic. The reports from the nurse and his examination revealed satisfactory progress. However, continuation of the same treatment for another week was considered advisable. Mr. Gay was perturbed because college examinations would be coming up soon. Nevertheless, he decided to undergo the treatment rather than risk the need for later hospitalization. He was determined to study with renewed energy at home and he also worked out a plan to minimize walking on his return to school the following week.

The public health nurse's visits were authorized for a second week. At the end of this time Mr. Gay's condition had improved, and the physician felt he could safely resume his classes. His activity plan was considered satisfactory too. Mr. Gay's reaction to the community nursing service is expressed in these remarks to the clinic physician: "I would have had to return to the hospital and leave my wife and son alone if you hadn't sent the visiting nurse. The boys would never have brought my assignment that far and I couldn't have studied there, either. Do you know, that nurse got talking to my wife about a sore she had had on her neck for a long time. The nurse persuaded my wife to go to the clinic and the doctor has been treating it with x-rays."

Seventy-two patients received nursing care during the test period. They had thirty different diagnoses. Multiple sclerosis, tuberculosis, and osteomyelitis occurred most frequently. There were patients with postoperative conditions, amputations, duodenal ulcer, et cetera. A total of 1,182 visits was made, with an average of 16.4 visits to each individual over the six-month period; 18 patients required daily visits, 12 twice weekly, and 13 three visits a week. The frequency of visits tapered off as families learned the care they should give, or as the patients' conditions improved. At the end of the test period nineteen patients were still in need of nursing care. All the patients benefited from the program. The manager of one of our tuberculosis hospitals wrote: "The patients receiving follow-up nursing care have been enthusiastic. To date six patients have been referred for home care. Five were patients on leave and one was a patient who had been discharged. One of the patients permitted to go home on leave was sputum positive, the remainder sputum negative."

Home nursing care was requested by the VA regional office physicians almost three times as frequently as by the fee basis or VA hospital physicians.

THE PILOT STUDY OF community nursing program reemphasized the value of home nursing care to patients needing such care. The improvement in the condition of these patients is proof. The value of this service to physicians need not be elaborated upon. Hospital regional office and fee basis physi-

(Continued on page 512)

Civil Defense

THIS IS CIVIL DEFENSE

NEWEST IN THE official U. S. Civil Defense booklets, *This is Civil Defense* defines and explains civil defense as a way of saving lives. It is a way of protecting people in case of war and helping them to keep going in spite of atomic, biological, or chemical attack. We know now that enemy planes can reach every major city in the United States. And enemy planes can carry atomic bombs, nerve gases, and biological warfare to everyone's doorstep.

Can we defend ourselves

General Hoyt Vandenberg, chief of staff of the United States Air Force, believes that seven out of every ten planes attacking the United States could get through to their targets, in spite of our defending air force and antiaircraft installations. The entire strength of the German air force could not stop our attacking bombers. That is where civil defense comes in.

We cannot prevent enemy attacks from happening, but we can keep them from knocking us out. There are defenses against the effects of an atomic bomb. There are ways of keeping disease from spreading, of protecting our food and water supplies. We can be prepared to prevent the worst effects of poison gases from taking place. All of these methods are civil defense.

If a bomb falls

If only one atomic bomb were dropped on a city many thousands would be killed instantly and thousands of others would be injured or buried beneath debris and in need of immediate care. Fires would start in minutes. Food, water, and transportation would surely be cut off. Without civil defense a nation is helpless.

There are many problems in civil defense, but most of all we need trained workers. Some 15,000,000 Americans must receive civil defense training immediately. Intensive education in self protection must be given to 135,000,000 more. Those figures add up to the entire population of this country and mean that every American must be trained or educated in civil defense. Each of us has a job to do and must learn to do it. Civil defense means you protect yourself and others if trouble comes.

The federal government does the planning and gives technical information to the states, but the operation of civil defense begins with the state. The Armed Forces have nothing to do with civil defense, yet they will work with civil defense officials on such problems as blackouts, dimouts, camouflage, and radio silence.

What you can do

Civil defense gives you information on how to safeguard your own home. It arranges for shelters and the warning systems that tell you when to go to those shelters. It is also amassing quantities of medical supplies and technical equipment. Already many cities have drawn up agreements to help each other in case of disaster. If your city is struck a nearby town might send its fire, police, and rescue crews to help out. You can volunteer to serve in any of ten services—all of them vital.

The warden service is the backbone of civil defense. It is the warden's job to save lives. Wardens must be well known and respected

and their leadership must be accepted by the neighborhood. The warden's job is to conduct people to safety, prevent panic, and render first aid. The fire service will naturally fight fire. They will take care of small fires wherever they start because the regular fire companies will be fully occupied with the main fires. People in target areas must learn to fight fires at home and at work.

The police service, too, will need many volunteers. Such auxiliary police will aid the regular police in the control of traffic and the control of panic. All persons who have had any training in medicine will be needed for the health service. But other volunteers are needed as litter bearers, ambulance personnel, hospital orderlies, and maintenance workers. Many thousands of clerical workers are needed by the health services to do clerical and laboratory work.

Women will be especially interested in the welfare service. If an attack comes the welfare service will gather and pass on news of people who are separated from their families. Women will also be needed to feed large numbers of people or distribute clothing or care for homeless children. Closely connected with the welfare service is the rescue service. Rescue work is mainly an engineering job. It requires some basic engineering knowledge and team members will be drawn from the building trades and similar occupations.

These are just some of the vitally necessary services which add up to civil defense, and civil defense is here to stay. Wars today are won or lost on the home front, and the home front can never retreat. That puts the problem squarely up to you!

Send to the Government Printing Office, Washington 25, D. C., for your copy of *This is Civil Defense*. Price ten cents.

The VA Community Nursing Program

(Continued from page 510)

cians were gratified by the results of the nursing care for their patients. The saving to taxpayers is worth mentioning, when we realize that had many of these seventy-two individuals not had nursing care at home more expensive hospitalization would have been inevitable. As an illustration, one patient needed nursing care three times a week for six weeks. The cost of this care was $31.50. Fee basis medical care, medications, and dressings supplied by the regional office totaled $40. If this particular patient had been returned to the hospital for six weeks the cost would have been $580 for forty days.

The success of the pilot study has led to the establishment of the VA community nursing program throughout the United States. Community nursing agencies which have not already entered into contractual arrangements with the Veterans Administration may obtain information about such contracts from the chief, nursing unit, of the local or nearest VA regional office.

American Journal of Nursing for September

Safeguard the Mother's Breasts . . . Ernestine Wiedenbach, R.N.

Defense Is Everybody's Business . . . Edith M. Beattie, R.N.

The Nurse and Sight Conservation . . . Helen E. Weaver, R.N.

Be Smart—Eat a Good Breakfast . . . M. Estelle Ingoldsby, R.N.

Never Too Old to Learn . . . Ruth E. Nelson, R.N.

Needed—Better Preparation for Venereal Disease Nursing . . . W. G. Simpson, M.D., and Virginia Murphy, R.N.

Abstracts . . .

HEALTH INSURANCE IN SASKATCHEWAN

Two of Canada's ten provinces, Saskatchewan and British Columbia, have embarked on universal coverage health insurance plans. In both provinces programs of compulsory hospital care insurance are in operation. Moreover, a pilot plan in compulsory medical care insurance for a large area has been in operation since July 1946 in Saskatchewan.

Situated just north of Montana and North Dakota, Saskatchewan is an extension of the Great Plains region. The province is almost as large as Texas but most of the people live in the southern part, where there are fewer than seven people per square mile. It is wheat and ranching country with approximately 80 percent of the population living in small communities or on farms. Only four cities in the entire province have populations of more than 10,000; the largest city has a population of 70,000.

Through cooperative and governmental action the people of this rural area have learned how to tackle some of their acute health problems. Best known of all the health developments are the municipal doctor plans. As early as 1914 rural municipalities offered first retainers and then salaries to attract physicians. Through a property and personal tax the municipality is able to give a salary and free office space to the doctor. There are one hundred twelve such municipalities with medical plans in operation—some on a fee-for-service basis.

Many other health programs are now in progress. An outstanding program of tuberculosis control has been built up at no charge to the patient. Diagnosis and treatment of cancer are on a completely tax-supported basis and every patient is entitled to receive without charge radiologic therapy, surgical care, and hospitalization. Mental services are also available on the same basis.

People receiving full assistance, old and blind pensioners, mothers receiving special allowances for dependent children, and people in related categories have been entitled to receive medical care, hospitalization, drugs, fairly complete dental care, and other benefits since 1945.

The hospital services plan in the province was organized to meet the needs of the entire population. The plan covers all residents of the province except those already provided for by other programs. Financed in part by personal taxes, in part by general revenue, the program provides practically complete benefits. These include the use of operating rooms, laboratory tests, x-ray therapy, most drugs, blood plasma, and physiotherapy. No limits are imposed on length of stay in a hospital, but there are no outpatient benefits. The incidence of hospitalization was 200 cases per 1,000 in 1949 as compared with 156 cases per 1,000 in 1947.

Under the Hospitalization Act the hospitals throughout the province are under independent management. The government feels that controls are unnecessary as long as high standards are maintained, but at the same time tries to assist with consultative services, and helps to train technicians and administrative personnel. Finally, the plan has developed a method to assure the hospitals sufficient revenue to cover their operating costs, provided they are efficiently managed. Stable financing has a definite bearing on sound hospital planning. Through the hospitalization plan there is an assurance of maintenance of rural hospitals in areas which ordinarily would find it impossible to support such facilities.

The development of fulltime public health services has been given a high priority in the

province. The concept is that the local health unit will be the center for medical care services, as well as public health activities. Six regional units have already been set up and one area, the Swift Current Health Region, has instituted a program of medical care insurance. This program is now in its fifth year of successful operation. It serves about 50,000 people in an area of 12,000 square miles. The medical profession has had a close, cooperative working relationship with the program from the beginning. Care is provided in the office, home, and hospital by thirty-five physicians. There is no direct charge for this care—which includes preventive, diagnostic, medical, surgical, and obstetric services—but there is a mileage charge for home visits. Of the annual budget of $700,000 the people contribute about 90 percent, with provincial grants of 10 percent.

To the familiar principles of prepayment of the costs of hospital care and the free choice of hospitals for the patient have been added universal coverage, unrestricted benefits, and the right of indigents to full participation in the program. Not only is there governmental financial participation but there also is active support to hospitals as they strive to improve standards of care.

This material has been abstracted from "Universal Coverage Health Insurance In Saskatchewan" by Frederick D. Mott, M.D., in the March 1951 issue of *Pediatrics*.

WAR AND CHILDREN

The effects of war on a child depend on three aspects of the child's experience:

1. Where the war is in relation to the child. Is it something he hears about or sees pictures of, or is it so close at hand that he sees, hears, and feels it?

2. What the war does to his family. Does he move from place to place? Does his mother go to work? Are his parents injured or killed?

3. What kind of child he is. How old is he? What is his personal integration? How much anxiety and aggression has he stored within himself?

The infant's wellbeing and security depend on the satisfaction of his sensory and physiologic needs. His security comes from the pleasure he gains from suckling, the warmth of his mother's cuddling, the soft rhythm of her voice.

But war can mean that a mother is anxious or frustrated and transmits her tenseness to her baby. A baby's most traumatic experience comes when he is separated from his mother during time of war, for even the most inadequate mother is better than no mother at all. Emotional tensions and anxieties learned in infancy are difficult to undo in later life.

There should be no plan for evacuation from emergency areas of children without their mothers. Mothers of infants should be the last source of manpower, and if they are employed provision should be made to care for the infants in line with the best principles of mental hygiene.

Young children between the ages of three and six do not understand the meaning of war. Certainly the child will be interested in what he sees and hears, but will be concerned only if war intrudes into his family life. There is anxiety if he is separated from his mother, for he fears she will not come back. Separation from the father is less disturbing unless the mother transmits her own anxiety to the child.

Separated from the father, the child becomes closer to his mother. He receives more of her attention, which can be a very satisfying thing, but it may also hinder his future development if he is kept on an emotionally infantile level. The absence of the father may interfere with the normal psychosexual development of the boy, for he does not learn to identify with his own sex. The father who returns from war to find his son timid and effeminate is likely to be disturbed and bring pressure on his son before establishing a bond of affection between them.

Aggressiveness in young children also increases during wartime because of the increasing number of frustrating situations in which the young child finds himself. He may be living in crowded quarters, with irregular schedules, or in a strange neighborhood with strange children. It has been found that children whose fathers were away showed less

tendency toward aggression than children whose fathers were home. This seems to indicate that with fathers away mothers are more indulgent with their children, because they have more time to devote to them and because they need the emotional satisfaction their children bring them. There is also the possibility that conflicts between mother and father about discipline confuse the child.

Play is the natural outlet for a child's emotions. A child who can play out "Mummy goes away—Mummy comes back" gets a reassurance that it will happen. If a child can kick his doll instead of his father or mother, he finds release in an acceptable way. The wish to hurt people undergoes many changes during the growth process. If it is suppressed during early childhood it remains as a source of conflict.

The more mature school age children are better able to handle their psychological problems. Yet those children who carry with them the fears and hostilities of their earlier years will be more vulnerable to the extra pressure of wartime. School age children are more realistic and want to know about the most minute details, for with knowledge and understanding comes their feeling of adequacy. They want to have a part in the adult world. However, these children face postwar problems too. There is a tendency in this age group to build up an idealized stereotype of the father. This may actually be a handicap in the establishment of realistic father-child relationships.

The program for this age group should be centered in the elementary school, for this can be an important source of security to the child. The school staff should be supplemented by people trained in social work and mental hygiene. People trained to work with children should not be drained off into industry.

Children, however, flourish best in peace. They need freedom to develop to the limit of their potentialities. In wartime all we can do is hold the line.

Abstracted from "Effects of Mobilization and War on Children" by Lois Meek Stolz in the April 1951 issue of *Social Casework*. Paper given at Midcentury White House Conference on Children and Youth.

HORIZONS FOR CHILDREN

Highlights of the Midcentury White House Conference on Children and Youth, of particular interest to those in the field of nutrition were a series of technical statements on nutrition. These covered changes in concepts and practices in nutrition; reviewed the nutritional requirements and status of children, the adequacy of family and children's diets; indicated factors which affect the child's intake; summarized recommendations made by various national health groups; and speculated about the areas in which more research and more application of research findings are needed.

One of the most exciting results of the 1950 factfinding report is the one which tells of an increasingly better diet for families. Trends in national food consumption tell the same story—that diets are improving with the times, the economic situation, and the advancement in nutritional knowledge. The 1942-1948 consumption of meat, poultry, fish, and eggs increased 30 percent for the lowest economic group of the nation, while milk products (except butter) tomatoes, citrus fruit, and green and yellow vegetables rose 20 percent.

On the other hand, there is evidence of general undernutrition and mild forms of specific malnutrition in some sections of the country. Listlessness and apathy are well recognized concomitants of such borderline nutritional status and often respond dramatically to better feeding. A careful analysis of general figures reveals that half of our children live in one-sixth of our families, with yearly incomes of less than $3,000. Just as the money that a family has bears little relation to the number of children, so states and regions which are rich in children may also be poor in terms of community services.

Other studies show that children of elementary school age have better average diets than older children. During adolescence boys eat more and get better diets than girls. This poor food selection and consumption by adolescent girls is of real concern, in view of the great role played later by proper diet for the pregnant woman and her newborn child.

The past decade shows an increasing tendency to relate food intake to other factors.

The recent surge of interest in psychosomatic illness and in mental health has reemphasized the relation of food to mental health and the relation of mental health to physical health.

One of the applications of this newer point of view is to "humanize food practices in children's wards." This is an effort to temper dietetics with mental health. In hospital wards, where so much emphasis is placed on nutrition, trays of high caloric high vitamin foods are often sent back to the kitchen with much uneaten food. With no extra money or food expended by the hospital it would take just a little effort and thought to individualize the eating problems. Small, child-sized portions do not threaten a child so much as a heavily overladen plate. A small spoon is of great advantage to a small child, and baked potatoes would be eaten more readily if someone would first break the tough skins.

Looking into our daily practices and unsolved problems we find new interest in determining when an infant is psychologically able to swallow cereal. We watch to see when a baby is hungry instead of trying to adjust him to a clock. We would like to know which cultural factors affect food habits desirably and how they may be promoted. We would like to know the effects on emotional development of child feeding practices both in families and group situations such as those in institutions.

These are some of the wider horizons for children. We must remember that what we *are to* children is more important than what we *do for* them.

Abstracted from an article in the April 1951 *Journal of the American Dietetic Association* by Leona Baumgartner, M.D.

VENEREAL DISEASE CASEFINDING

The problem of finding persons with syphilis and preventing its spread by having them seek early medical attention is still a real one. In the general population there is a reservoir of undiscovered persons with syphilis who are not being diagnosed or treated while they are still in the early stage of the disease. This is a known certainty based on the greater number of reported cases in the latent stages than in the primary or secondary stages. These missed persons remain in the population without treatment and are responsible for the spread of syphilis. Therefore it is most essential that nurses evaluate the effectiveness of all casefinding procedures in order that maximum casefinding results be obtained from their efforts. The casefinding methods usually employed are (1) contact investigation (2) education (3) routine serologic tests, and (4) mass survey.

In determining the relative value of casefinding procedures we are concerned with methods which are efficient, economical, and yet productive in having persons seek early medical care.

Gumpert, Ingraham, and Burke report a casefinding campaign in a high incidence area based on community education. The article describes the procedures used in the Philadelphia casefinding campaign which was held from June 15 to November 15, 1949. Precampaign planning was based on the theory that educational methods for casefinding should be concentrated in areas of the population where venereal disease prevalence was known to be high. Also the socioeconomic characteristics of the people living within the areas should be determined in order to ascertain the type of informational material that would be most productive. Aid from professional and civic groups was enlisted. Emphasis was placed upon one readily accessible diagnostic center, and the address of the center appeared on all campaign material. Some of the campaign materials used were a tabloid newspaper, car cards, sound trucks, newspaper stories and advertisements, juke boxes, radio and television, leaflets, and street banners. Data supplied by patients as to their reason for reporting were recorded and will be the subject of a second paper, and the evaluation of the effectiveness of the campaign will be the subject of a third paper.

This is an abstract of "Venereal Disease Case Finding in High-Prevalence Areas, I. Procedures Used" by G. Gumpert, N. R. Ingraham, Jr., M.D., and M. J. Burke in *Journal of Venereal Disease Information*, March 1951.

New Books
And Other Publications

MODERN TRENDS IN OBSTETRICS AND GYNECOLOGY

Kenneth Bowes, editor. New York, Paul B. Hoeber, Inc., 1950. 778 p. $12.

This books presents modern trends in obstetrics and gynecology and in obstetrics and gynecology as branches of medicine which influence and are influenced by the advances of general medicine and biology. One third of the book is written by authors who have some particular contribution to make to obstetrics and gynecology from the fields of anatomy, physiology, psychiatry, eugenics, pathology, medicine, and law. These chapters are drawn from experience and research in England, Scotland, Ireland, Wales, Canada, New Zealand, Denmark, Sweden, and the United States. While much of the material presented reflects British work the book is definitely cosmopolitan in character and the author is to be complimented for an excellent piece of interprofessional and international work.

Of special interest to the public health nurse are the chapters on statistical and genetical problems, psychological factors in obstetrics and gynecology, social factors in obstetrics, lactational physiology, aspects of fetal physiology, fertility and infertility, and the law in relation to obstetrics and gynecology, for here she will find a wealth of carefully presented factual data to aid her as a teacher.

To the clinician and teacher the book is an invaluable inspiration. As he reads he is skillfully led through the intricacies of research and practice to a recognition of the general direction each is taking and to an awareness of their presentday interdependence. This book may well become known as a classical example of the kind of contribution the specialist can make to the future work of the clinician.

The contents of the book are well documented and the references are largely those of the past ten years, which have been chosen because they either bring the subject up to date or present some new discovery or unique pattern of practice. It is not a "book which forms the basis for regular class instruction" but it is a book which supplies one with a dynamic challenge to think as he works in these special branches of medicine.

—HATTIE HEMSCHEMEYER, R.N., *Associate Director, Maternity Center Association.*

I TOOK IT LYING DOWN

Marian Spitzer. New York, Random House Inc., 1951. 247 p. $2.75.

As Marian Spitzer says in her book, she had it "easier" than most tuberculous patients. She stayed at home. She had all the medical and nursing care that money could buy. She had an understanding and considerate husband. And she had the help necessary to fulfill most of the needs of her children and to keep her household running smoothly. However, she faced the same psychological problems that other patients face: rebellion, discouragement, inability to believe that she could be ill with tuberculosis, the need to change her way of life, knowledge that the greatest share of the responsibility was placed upon her as to whether or not she was to get well. These are all familiar to tuberculous patients. The dependency which she hated, the need for replacing this by assuming independence as she recovered, are all graphically told in this story of her illness.

One wishes that she had had a more understanding nurse, one who was not just an automaton, giving excellent physical care, to be sure, but utterly lacking in any understanding of the patient as a person needing her supportive care.

This book will be helpful to many patients and to their families. Others will feel that Marian Spitzer did have it "too easy" because she did not have to face some of the social

and economic problems that the majority of tuberculous patients and families must face if their tuberculosis is to be conquered.

The appendix gives a brief and understandable explanation of various surgical procedures used in the treatment of tuberculosis.

—JEAN SOUTH, R.N., *Public Health Nursing Consultant, Joint Tuberculosis Nursing Advisory Service.*

THE PRACTICE OF SANITATION

Edward S. Hopkins and Francis B. Elder. Baltimore, Williams and Wilkins Company, 1951. 423 p. $7.50.

This book is very easy to read. It attempts to cover the wide variety of subjects that are of concern to the sanitary engineer and the sanitarian as well as to health officers dealing with problems in the field of environmental sanitation. The ambitious attempt to provide such wide coverage in a single volume is well made and the book affords a general insight into most of the problems and control methods in the field. For greater details the reader can make use of reference books on the various topics. It might add to the usefulness of this book if at the ends of the various chapters, along with the literature cited, the many excellent available reference books on the individual topics were listed.

The subjects discussed cover municipal and rural water supply and sewage disposal systems, food sanitation, sanitation of milk and milk products, stream pollution problems and control, disposal of garbage and rubbish, ventilation, swimming pools and bathing places, air contamination, housing, insect and rodent control, together with a review of the principles of disinfection, administrative procedures for sanitation control, and other general considerations. The book contains a considerable amount of ready reference material that should be especially useful to the sanitarian and the health officer, and will give to other interested persons a large amount of information relative to the field of environmental sanitation.

—WARREN J. SCOTT, *Director, Bureau of Sanitary Engineering, Connecticut State Department of Health.*

THE HISTORY OF THE NATIONAL NURSING COUNCIL

Hope Newell. Copies available from NOPHN, 2 Park Avenue, New York 16. 1951. 113 p. $2.

Mrs. Newell has brought to the attention of her readers a clear picture of the many programs which were carried forward by the National Nursing Council. She has presented a blueprint for united action, the kind of blueprint that can be most helpful in planning for present and future nursing needs.

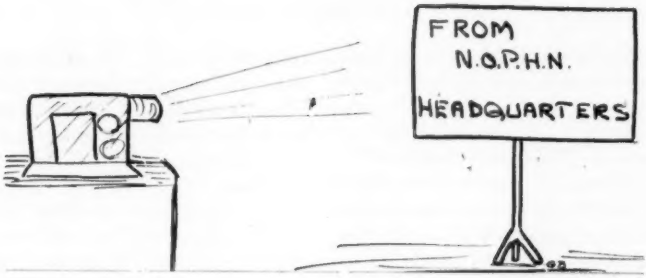
Nurses, with the cooperation of the allied professions and the lay public, developed within the council sound patterns for meeting military and civilian needs in a national emergency. The present joint committees, including the Coordinating Committee on Structure, received impetus from the council. For the first time in the history of nursing board, staff, and committee appointments were made solely on the basis of qualifications. In doing so the council has presented a challenge to nursing which can be most helpful now and in the future. Also, for the first time through coordinated effort the needs of all groups were recognized.

The value gained from the work of the council will be a lasting testament to the vision and courage of those whose privilege it was to serve this unique organization.

—MABEL K. STAUPERS, R.N., *former president,* NACGN.

WE ARE SORRY FOR OUR ERROR

Foundations of Community Health Education, **by Robert G. Paterson (McGraw-Hill Book Company) was reviewed in the July issue, page 394, by Mabel E. Rugen, Ph.D., Professor of Health Education, University of Michigan. Mistakenly we listed Miss Rugen as an R.N.**



ADA M. CARR

We have learned with deep regret and sorrow of the death of Ada M. Carr, editor of PUBLIC HEALTH NURSING from 1923 to 1930. When she left the NOPHN in August 1930 Elizabeth G. Fox, then chairman of the Publications Committee, presented a resolution to the board of directors. This read in part as follows:

"For many years the magazine and Miss Carr have been inseparable in our minds. Its quality we owe almost entirely to her. . . . In its pages she has brought into focus every fresh idea and new growth which seemed to hold the germs of progress for our work, and through fostering them diligently, has given them a place in our thinking and in our practice.

"The greatest tribute we can pay to Miss Carr will be to keep the magazine at the high level on which she has always maintained it and to carry her spirit into all that we may do."

Miss Carr, a graduate of Johns Hopkins Training School for Nurses, was the first superintendent of the Baltimore Visiting Nurse Association. Later she was on the staffs of the Boston Instructive Visiting Nurse Association and the Instructive Visiting Nurse Association of Providence.

The magazine has known four editors since Miss Carr's resignation. All have appreciated how soundly Miss Carr directed the young publication through the 1920s and all have taken inspiration from her work. We shall continue to strive to carry on in the way she would want us to.

COLLEGIATE COUNCIL

The Collegiate Council on Public Health Nursing Education, a section of the NOPHN, will hold its fall meeting October 10-13 at Haven Hill, Michigan. The program has been planned as a work conference to consider the overall topics of (1) public health nursing as a special area of nursing and (2) responsibilities of the beginning public health nurse working under direct supervision in public health nursing services. The Program Committee consists of Elizabeth Hilborn, chairman, and Essie Anglum, Anna Hassels, Gertrude Hess, and Marion Murphy.

UNESCO

The Third National Conference of the U. S. National Commission for UNESCO to be held in New York has been postponed from September to January 27-31, 1952. (See PUBLIC HEALTH NURSING, July, p. 404) The theme of the conference is "citizen understanding as a force in an interdependent world." Frances M. Frazier of Teachers College, Columbia University, and Margaret L. Varley of Harvard School of Public Health are the NOPHN representatives to the conference.

STAFF NOTES

During the summer several changes occurred in the Joint Orthopedic Nursing Advisory Service staff at headquarters. To assist in the increased activities associated with the poliomyelitis "season" Anita Searl, Mary L. Kerr, and Barbara Williams joined the JONAS group on a temporary basis. Miss Williams returned to the regular staff, replacing Miriam

Crouch who left on September 1 to become instructor in orthopedic nursing at Boston University.

Miss Williams is a graduate of Children's Hospital School of Nursing in Boston, and of Teachers College, Columbia University. She has had extensive experience in orthopedic nursing, especially in poliomyelitis work. Her last position was instructor and supervisor of orthopedic nursing at Children's Hospital in Boston and supervisor of the respirator unit at the convalescent home of Children's Hospital. Miss Williams prepared the chapter on poliomyelitis in *Orthopedic Nursing* by Knocke and Knocke. She and Teresa Fallon represent the NLNE on the JONAS staff.

Helen S. Hartigan joined the NOPHN orthopedic consultant on the JONAS staff on July 1. Miss Hartigan was born in Cherokee, Iowa, and had her early schooling there. She is a graduate of Mercy Hospital, Chicago, and of Western Reserve University, where she took her public health nursing study. Miss Hartigan also studied physical therapy at Harvard and at Northwestern Universities. She has done generalized public health nursing with the Chicago VNA and also served as specialized orthopedic nurse in that agency. She was in the Army Nurse Corps for three years. Before coming to JONAS Miss Hartigan was supervisor, Nursing Services, State Crippled Children's Service, in Columbia, Missouri.

In mid-September Frances E. Goodman also came to headquarters as a member of the JONAS staff. Miss Goodman, a native of Glasgow, Kentucky, is a graduate of Nazareth College and of Norton Infirmary, both in Louisville, and of Teachers College, Columbia University. During the war she was in the Army Nurse Corps. In 1946 Miss Goodman joined the Kentucky Crippled Children Commission as orthopedic public health nurse and was assigned for part time as supervising nurse to the Kosair Crippled Children Hospital in Louisville.

Claire M. Mintzer has been appointed psychiatric nurse consultant to the NLNE-NOPHN project in psychiatric nursing. Miss Mintzer is a graduate of Wagner College School of Nursing and of Teachers College, Columbia University. She will work with Bessie Littman, the public health nurse mental health consultant, in this project.

ABOUT PEOPLE YOU KNOW

The Veterans Administration announces the appointment of *Harriet T. Rapp* as chief, Nursing Unit, at the VA Regional Office in Providence, Rhode Island, and *Grace M. Ferguson* to a similar position in Atlanta, Georgia. Miss Rapp formerly was director, Visiting Nurse Association, West Chester, Pennsylvania. Miss Ferguson has recently been field advisory nurse, Mississippi State Board of Health. . . . *Margaret Elizabeth Kindle*, a graduate of Talladega College and Harlem Hospital School of Nursing (New York) has been appointed to the supervisory staff of the Detroit Board of Health. Miss Kindle also attended Wayne University, where she completed her study in public health nursing.

Seton Hall University conferred the degree of Doctor of Laws on *Mrs. Caroline di Donato Schwartz*, dean of the School of Nursing at the university. . . . *Mamie Odessa Hale*, public health nursing consultant, Arkansas State Board of Health, is the recipient of a WHO

Helen S. Hartigan

Frances E. Goodman

Barbara Williams

fellowship for study abroad. Miss Hale is now in Europe where she will observe maternity, midwifery, and child health programs. She is a graduate of Freedmen's Hospital School of Nursing in the District of Columbia, and has studied public health nursing at Western Reserve University, Simmons College, and Teachers College, Columbia University. She is also a graduate of the Tuskegee School for Nurse Midwives.

Mrs. Patricia Gerold Hughes has been appointed an assistant supervisor in the Visiting Nurse Association of Brooklyn. During the war Mrs. Hughes served as an Army nurse. She is a graduate of St. Vincent's Hospital School of Nursing (New York) and St. John's University. . . . *Gyla Brooks,* formerly with the Pittsburgh VNA and now employed by the Association for the Aid of Crippled Children in New York, has recently been appointed educational coordinator of the Children's Division of the Institute for Physical Medicine and Rehabilitation, Bellevue-New York University.

NOPHN FIELD SCHEDULE—AUGUST

Marjorie Adams	Greenville, S. C.
Hedwig Cohen	Washington, D. C.
Helen Hartigan	Shreveport, La.
Mary Kerr	Norwalk, Conn.
Anita Searl	Winona, Minn.
Jean South	Syracuse, N. Y.
Judith Wallin	Quincy, Ill. St. Louis, Mo. Chattanooga, Tenn. Owensboro, Ky. Lexington, Ky. Middletown, Ohio

July field trips not previously reported: Marjorie Adams, Gadsden, Ala.; Judith Wallin, East Chicago, Ill.; Helen Hartigan, Fort Dodge and Council Bluffs, Iowa; Mary Kerr, Lansdowne, Pa., Shreveport, La., and Montgomery, Ala.; and Anita Searl, Charlotte, N. C., Akron, Ohio, and Greenwich, Conn.

WHERE ARE THEY NOW?

If you know the present address of any of the following individuals will you please send a postcard with this information to NOPHN headquarters so that we may bring our records up to date? Last known addresses are given here.

ALABAMA
Barclay, Anna P., State Department of Health, Montgomery

ARIZONA
Arline, Mrs. Anita S., 710a College Ave., Tempe
Wellman, Mrs. Imogene M., 325 N. 16 St., Phoenix

ARKANSAS
Trice, Mrs. Lillian C., Greene County Public Health Nurse, Paragould

CALIFORNIA
Agnes, Edith A., Letterman General Hospital, San Francisco
Bowen, Mrs. Thelma, 1229 Sam Ave., Modesto
Bowit, Audrey M., 2617 Durant, Berkeley 4
Darrow, Marianne, 1003 Carlton St., Berkeley
Du Bord, Betty, ARC Visiting Nurse Service, Burlingame
Ferguson, Florence, 491 Dawson Ave., Long Beach
Fisher, Lillian, P.O. Box 13162, Los Angeles 25
Humphreys, Charleen, 2630 Haste St., Berkeley 4
Kangan, Marie B., 212-3rd Ave., San Francisco 18
Jones, Ruth E., 1384 Madera, Menlo Park
Lindesmith, Rosalind M., 1035-75 Ave., Oakland 2
Morse, Kathryn A., 1250 S. Marengo Ave., Pasadena
Pruitt, Anne, 1647 Bancroft Way, Berkeley 2
Ramsey, Mrs. Ardoth R., 1736 La Cadena, Riverside
Strom, Jeanne, 424 Stanyan St., San Francisco

CONNECTICUT
Donnelly, Mary A., 356 Fern St., W. Hartford
Southward, Mae A., 53 Prospect St., Stamford

DELAWARE
Campbell, Grace, 10 Valley Road, Wilson 166

DISTRICT OF COLUMBIA
Porter, Merilys E., 419-4th Street, N.W., Washington
Sprague, Elfreda, Pan American Sanitary Bureau, 2001 Connecticut Ave., Washington

GEORGIA
Nicholson, Battey, 23 E. Charlton St., Savannah
Richards, Mrs. Evelyn, 786 Marion Ave., S.E., Atlanta

IDAHO
Johnson, Edith M., Rt. 2, Pocatello

ILLINOIS
Bannon, Ruth A., 2746½ Hampden Ct., Chicago 14
Klevering, Delia J., 1804 W. Congress, Chicago
Peterson, Marie, 1001 N. Dearborn, Chicago
Townsend, Florence, St. Mary's Training School, Des Plaines

(Continued on page A10)

NEWS AND VIEWS

CHILDREN'S BUREAU STAFF CHANGES

Katherine Lenroot, chief of the Children's Bureau for the past seventeen years, retired from that position on September 1, 1951. President Truman has appointed Dr. Martha M. Eliot to succeed Miss Lenroot.

Miss Lenroot has been associated with the Children's Bureau since 1915, during which time the bureau has given dynamic leadership in promoting the welfare of children. Miss Lenroot was executive secretary of the White House Conference on Children in a Democracy in 1940 and secretary of the Midcentury White House Conference held last December. She has represented the United States at many international conferences concerned with child care.

Dr. Eliot, too, is well known to public health workers. For the past two years she was assistant general director of the World Health Organization, where she pioneered in developing public health services in many countries requesting help from WHO. Before going to WHO Dr. Eliot had been associate chief of the Children's Bureau. In 1948 she was given the Lasker award for her work with EMIC.

The Children's Bureau also announces the appointment of Dr. Sarah S. Deitrick as director of the Division of International Cooperation. She will develop plans for the bureau's participation in the Point IV program. Dr. Deitrick was formerly chief of the Field Operations Branch of the Division of Health Services. Before joining the bureau in 1936 she was with the New York State Department of Health.

SILVER NITRATE VERSUS PENICILLIN

The National Society for the Prevention of Blindness went on record in June as favoring continued use of 1 percent silver nitrate solution as the preferred prophylactic agent in preventing ophthalmia neonatorum. There has been considerable research in the last few years on the use of penicillin rather than silver nitrate for this purpose. Dr. Franklin M. Foote, executive director of NSPB, said, "It was felt that additional scientific research should be carried on in well supervised training centers to explore further the effectiveness of various antibiotics, the question of sensitivity, and the possibility that strains of some bacteria may develop a resistance to certain of the antibiotics."

MABEL STAUPERS

THE SPINGARN Medal, presented each year for the highest achievement of an American Negro, was awarded to Mrs. Mabel K. Staupers at the annual convention of the National Association for the Advancement of Colored People.

Mrs. Staupers has been closely connected with the National Association of Colored Graduate Nurses and has done much to break down racial discrimination in nursing education and to further the status of Negro nurses in the United States. Just a few weeks ago the Graduate Nurses' Association of the District of Columbia voted to admit Negro nurses to membership in that organization. This leaves only four state nurses associations which continue to discriminate on the basis of color.

AHA MEETING

At the twenty-fourth scientific session of the American Heart Association in June a more hopeful outlook for rheumatic fever was ex-

pressed in a twenty-year follow-up report on 1,000 patients. The report, by Dr. Edward F. Bland and Dr. T. Duckett Jones, told of the progress of these patients who were admitted to the House of the Good Samaritan in Boston between 1921 and 1931 at an average age of eight years.

Chances of survival among the patients studied were found to be much better in the second decade of the project. By the end of the first ten-year period 202 of the original 1,000 patients had died. During the next ten years less than half that number died. A greatly enlarged heart or congestive heart failure early in the disease took the highest toll. The average age of the 699 patients who survived the twenty-year study period was twenty-eight. The majority were remarkably well. Four hundred twenty-one children had been born to the female patients, and the complications of pregnancy were minimal.

There was recurrence of rheumatic fever or chorea in approximately one in five during the first five years, one in ten during the next five years, one in twenty during the third five years, and much less frequently after that.

Dr. Herrman L. Blumgart of Harvard found that patients with certain types of chronic heart disease were successfully relieved by the use of radioactive iodine, which reduced the activity of the thyroid gland and thus lessened the work of the heart. Although their thyroid activity had been normal several of these patients suffered from angina pectoris and others had congestive heart failure. They had not responded to previously accepted medical measures.

An upset in the balance between two fatty substances in the blood is a possible cause of arteriosclerosis. It was found in a study conducted by Dr. Alfred Steiner, Dr. Forest E. Kendall, and Dr. James A. L. Mathers that there was an increase in the two principal fatty components of the blood—cholesterol and phospholipids—in patients with heart disease, but the cholesterol rose at a more rapid rate. This has great significance since it is believed that the phospholipids are responsible for keeping the cholesterol dissolved in the blood, preventing it from forming a fatty lining and narrowing an artery. When the increase in cholesterol gets ahead of the controlling phospholipids it is thought that the freed cholesterol may cling to the artery wall, narrowing it and reducing the flow of blood to the brain or heart. A sudden block in the supply to the heart, caused by the formation of a clot in a narrowed artery, is known as coronary thrombosis. When blood to the brain is cut off a "stroke" results.

The report concluded that it is becoming increasingly apparent that coronary arteriosclerosis is associated with widespread abnormalities in the pattern of fatty substances in the blood.

VNSNY HOLDS A WORK CONFERENCE

The administrative and supervisory staff of the Visiting Nurse Service of New York recently held a work conference on interpersonal relations. Four four-hour sessions were held at weekly intervals. The group explored such areas as proper use of authority, functions of leaders, and the ultimate aim of all individuals for social self realization. The participants recommended that methods of orienting staff to their responsibilities as senior advisers and as representatives to the Staff Council be studied and that ways should be sought for staff nurses to take part in policymaking.

As a result of the conference plans have been made which will change committee structure and committee functions. It is expected this will lead to broader participation of staff in policymaking, a goal in democratic administration.

INTERNATIONAL CONGRESS ON MENTAL HEALTH

The Fourth International Congress on Mental Health will be held in Mexico City, December 11-19, 1951, under the joint sponsorship of World Federation for Mental Health, Liga Mexicana de Salud Mental, and the Regional Office for the Americas of World Health Organization. Dr. Alfonso Millan, president-elect of the World Federation, is chairman of the Mexican Organizing Committee for the Congress.

The four major topics to be discussed at the plenary sessions are (1) mental health and

children; (2) occupational mental health—rural and industrial; (3) mental health problems of transplantation and migration, and (4) community efforts in mental hygiene.

There will be a series of technical meetings with speakers and discussants from the various countries and professions represented at the congress. In addition to these there will be fifteen to twenty-five international, interdisciplinary working groups, each composed of approximately fifteen professional people, who will meet daily to exchange ideas, to consider approaches found useful in various countries, and to make suggestions for future planning.

The congress registration fee for members is $12 U. S. currency. A fee of $6 for associate members (wives or others accompanying members) will entitle them to attend plenary sessions and any social events which may be arranged. Fees may be sent as a U. S. postal money order or a draft on a Mexican bank, although personal checks will be accepted from United States members. Checks should be made payable to the Fourth International Congress for Mental Health and sent to Dr. Alfonso Millan, Chairman, Organizing Committee, Gomez Farias 56, Mexico D. F., Mexico.

FAMILY HEALTH MAINTENANCE

The first family group to participate in the Family Health Maintenance Demonstration was greeted at the center at Montefiore Hospital in New York in early May. The demonstration is an experimental project, emphasizing the maintenance of health. A skilled team consisting of doctor, public health nurse, social worker, nutritionist, and other specialists will work closely with the families who volunteer to participate in the study.

The functions of the public health nurse in this demonstration are being worked out with the assistance of a nursing committee consisting of representative nursing leaders in New York City. The Community Service Society, one of the three sponsoring agencies, has assigned Helene Ringenbergen of the Department of Educational Nursing to the project team. The other interested agencies are Montefiore Hospital and the College of Physicians and Surgeons, Columbia University. (See also PUBLIC HEALTH NURSING, August 1950, p. 476-477.)

NATIONAL MIDCENTURY COMMITTEE ON CHILDREN AND YOUTH

A new national committee to carry out objectives of the Midcentury White House Conference on Children and Youth was organized on May 29, 1951. The new group, the National Midcentury Committee on Children and Youth, elected Leonard W. Mayo as chairman. Elma Phillipson, who was consultant on national organizations to the White House Conference, was appointed executive secretary.

The new committee will build its program upon the purposes accepted by the Midcentury White House Conference and will be guided by principles developed by the conference. Among the most important of these principles are that all services, programs, and facilities for children and young people be provided without discrimination as to race, creed, color, or national origin, and that youth should be included in all appropriate activities.

In light of the organization of the National Midcentury Committee on Children and Youth, the National Commission on Children and Youth has been discontinued. The new committee will make available a consultant service to state and local committees and national and federal organizations serving children and young people. Special attention is to be given to problems made more urgent by the present national emergency situation.

● The New York University Institute of Physical Medicine and Rehabilitation is offering a series of three-week seminars in physical rehabilitation methods for nurses, starting October 29, 1951, February 4, and May 12, 1952. Tuition is $50. The course is planned for graduate nurses who have had at least two years of experience in a hospital or public health nursing service. The instruction will be found applicable by staff nurses, supervisors, and nursing instructors.

For application blanks and additional information write to Miss Edith Buchwald, Institute of Physical Medicine and Rehabilitation, 400 East 34 Street, New York 16, N. Y.

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Where Are They Now?

(Continued from page 521)

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Culler, Eileen M., 1718 St. Joe Blvd., Ft. Wayne
Dearasaugh, Ethel, RFD 2, Cedar Lake
Galey, Margaret, 561 E. 37 St., Indianapolis
Herbig, Ovah, 315 W. 13 St., Anderson
Kremer, Virginia, Indiana University, Maple Hall, Box 189, Bloomington
Piper, Michelena, 318 N.W. L St., Richmond
Schurter, Emma, 205 E. Missouri St., Evansville

IOWA

Szablowski, E. M., 1432 Harding Rd., Des Moines
Westfall, Mrs. C. B., 316 E. Burlington, Iowa City
Moore, M. Alice, County Nurse, Clarion

KANSAS

Dickensheets, Dorothy, 304 South C., Arkansas City

KENTUCKY

Newman, Leona, 634 Camp St., Louisville 3

LOUISIANA

Graber, Cora L., 1122 Boone St., Bossier City

MARYLAND

Brady, Katherine, P. O. Box 331, Baltimore 3
Clear, Wilma, 2026 Park Ave., Baltimore 17
Davis, Mrs. W. P., Flat Top Acres, Rt. 4, Rockville
Leiper, Mrs. C. L., 5 Acton Pl., Annapolis

MASSACHUSETTS

Aldrich, Mildred, Holyoke Nurses Association, Holyoke
Andrews, Priscilla, 187 Huntington Ave., Boston
Price, Nancy, 97 Bay State Rd., Worcester
Tracy, Mrs. Gladys W., 40 Rockview St., Jamaica Plain
Ullrich, Florence, 2 Strong Place, Boston 14

MICHIGAN

Ahman, Virginia, 934 Greenwood, Ann Arbor
Baker, Mrs. E. J. P., 4863-2nd Avenue, Detroit
Edwards, Mrs. K. A., 1607 South St., Ann Arbor
Eggers, Lucile, 934 Greenwood, Ann Arbor
Johnson, Elizabeth, 1006 S. Forest, Ann Arbor
Lee, Sofia, 1911 Austin, Ann Arbor
Logan, Eva, Department of Health, Detroit
Newman, Mrs. Ruth, 960 Gladstone, Detroit 2
Pease, Millicent, 312 S. Thayer St., Ann Arbor
Peters, Flora W., 661 W. Forest, Detroit
Scherman, Esther, 916 W. Michigan, Lansing
Slinker, Mrs. Mary, 159 Plainfield, Inkster
Woznicki, Stephen, 3151 Farnsworth, Detroit 11
Yager, Anna, 520 E. William, Ann Arbor

MINNESOTA

Aver, Mrs. Mildred, 517 Essex S.E., Minneapolis 14
Bowman, Emma C., 925 S.E. 4 St., Minneapolis
Dau, Bernice I., 600-9th Avenue, S.E., Minneapolis 14
Downing, Francis I., 311-11 Avenue, So., Minneapolis
Fink, La Rue, Public Health Nursing Service, Rochester
Heneman, M. G., 515 Oak St., S.E., Minneapolis 14
Lindberg, Carol, 2103 Garfield Ave., So., Minneapolis
Loso, Dorine, 162 Virginia St., St. Paul 2
Riddell, Betty, P. O. Box 19008, Minneapolis 14

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(Continued on page A18)

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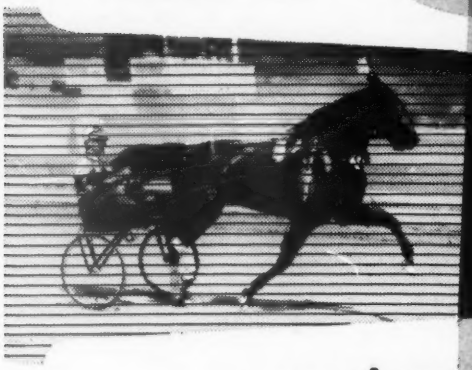

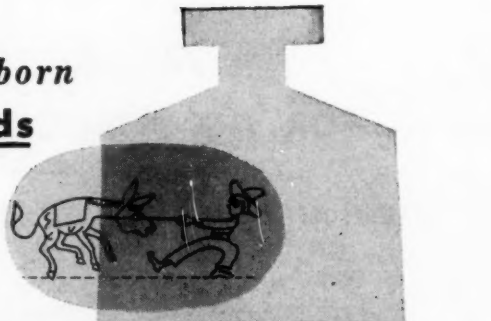

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1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

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MEN: Only 56 per cent of the men say they have good breakfasts.

INDUSTRIAL WORKERS: An industrial survey discloses the greatest number of accidents occurred in the last hour before lunch, and that a large majority of the injured had come to work without an adequate breakfast.

TEACHERS: 75 per cent of elementary and high school principals and teachers are in agreement that breakfast is most apt to be the neglected meal by the students and say it is a serious problem when students skip or slight breakfast.

DOCTORS: 68 per cent of the doctors say the average person eats too little for breakfast and 75 per cent of them think the average breakfast is poorly balanced.

UNCLE SAM: The United States Bureau of Human Nutrition and Home Economics says: "It has been found that workers who skip breakfast get less done in the first morning hours than those who tuck away a good breakfast before work."

BETTER BREAKFAST PROGRAM: In the past few years over 80 cities and several states have organized Community Better Breakfast Programs which, together with the above facts, indicate the need for a **National Better Breakfast Month** in September.

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After breakfasts that furnished 7 to 17 gm. of protein and 360 to 520 calories, the blood-sugar rose rapidly during the first half hour and returned to the original fasting level in three hours. After breakfasts which provided about 500 calories and 22 gm. of protein, derived chiefly from the animal sources, milk or eggs, the blood-sugar rise was normal, but the average maximal figure was lower and the return to fasting level was delayed beyond the usual three-hour period.

The sustained blood-sugar levels were associated with favorable physiological responses of the subjects. A sense of physical well-being was reported consistently following breakfasts that provided the larger quantities of protein-rich food.

Milk's contribution to the morning meal was demonstrated in one of the test breakfasts. By adding slightly more than a glass of milk to a low protein breakfast of about 350 calories, blood-sugar levels were longer sustained and the meal was more satisfying to the subjects than was the basic meal. The milk supplied not only the additional protein and food energy, emphasized in the present study, but provided many other nutrients needed for good nutrition.

It is evident from these findings that important nutritive changes in breakfast can be made with little variation in menu and with almost no effort. A glass of milk, for example, can make the difference between a good and a poor breakfast without adding materially to the time required either to prepare or to eat the meal.

*Orent-Keiles, E. and Hallman, L. F. *The breakfast meal in relation to blood-sugar values.* U. S. D. A. Circular No. 827 (Dec.) 1949.

The presence of this seal indicates that all nutrition statements in the advertisement have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

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(Continued from page A10)

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Busby, Ruth, 4201 Locust, Kansas City
Carroll, Mrs. Lelia, Municipal Courts Bldg., St. Louis
Corzine, Mrs. Dorothy L., Municipal Courts Bldg., St. Louis
Caulkins, Charlotte, Municipal Courts Bldg., St. Louis
Dever, Mrs. Alice C., Municipal Courts Bldg., St. Louis
Martin, Martha, 1325 S. Grand, St. Louis 4
Precup, Lena L., 2652 Oregon Ave., St. Louis 18
Price, Ora, Municipal Courts Bldg., St. Louis
Roussan, Myrtle, Municipal Courts Bldg., St. Louis
Stansbrough, Mrs. Ruth, 35 Municipal Courts Bldg., St. Louis
Taldt, Anne, 4322 McRee, St. Louis 10
Vermillion, Mrs. Mildred, Municipal Courts Bldg., St. Louis
Wehner, Alita, Municipal Courts Bldg., St. Louis

NEBRASKA
Ellingwood, Marion, 1036 S. 30 Ave., Omaha
Heise, Charlotte, 1021 Claremont, Lincoln
Roesky, Ardath, 3340 Taylor St., Omaha

NEW JERSEY
Bu Dres, Tillie, 19 E. 12 St., Linden
Derr, Kathryn, 15 Division St., Englewood
Hatch, Mrs. Eugene H., 319 Franklin Place, Plainfield
Hoenes, Mrs. Mary, 205 Ohio Ave., Absecon
Isenor, Lucille, 214 Virginia Ave., Westmont
Marshall, Mrs. H. P., 1007 Hillside Ave., Plainfield
Neuenhaus, Marion, 54 Knickerbocker Ave., Paterson

NEW MEXICO
Nance, Elizabeth D., Field Nurse, USIS, Zuni

NEW YORK
Arashiro, Ira, 510 W. 113 St., New York 25
Benton, Jessie E., 21 Niagara St., Lockport
Brady, Vera E., 320 W. 11 St., New York 14
Corbett, Mabel W., Box 616, White Plains
Donovan, Patricia, 250 Harrison Ave., Mineola, L. I.
Goetz, E. M., Collendale D-7, Syracuse
Harbut, Irene, 40-56-9 Street, Corona, L. I.
Horst, Esther A., 417 W. 118 St., Apt. 42, New York
Jensen, Mabel V., 11 Monroe Place, Brooklyn
Jones, Hilda S., 27 W. 120 Street, New York 27
Kasper, Hazel A., 17 E. Main St., Webster
Kearney, Margaret, 1440 West Ave., Bronx
League, Alma, 503 W. 121 St., Apt. 3, New York 27
MacDonnell, Eileen, 92-05-43 Ave., Elmhurst
Maxwell, Mrs. Nancy, 357 Midwood St., Brooklyn 25

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Beech-Nut FOODS for BABIES

Babies love them...thrive on them!

POSITIONS AVAILABLE

Advertisements in this column are accepted at the following rates: 10c a word with a minimum of $3 for 30 words or less, MONEY TO ACCOMPANY ORDER FOR INSERTION. Agency members or sustaining members may have ONE insertion up to 50 words without charge. Closing date for copy and cancelation is the 1st of the month previous to publication.

WANTED—Qualified staff nurses, well known combination agency. Program includes bedside nursing, maternal and child care, communicable disease nursing, parochial school nursing, clinic services; excellent salary schedule; beginning salary dependent upon preparation and experience; 40-hour week, liberal vacation, sick leave, retirement; accessible to universities carrying PHN programs. Write to Director, Public Health Nursing Service, 65 Chestnut Street, Montclair, New Jersey.

WANTED—Public health nurses, New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2,650; 37-hour week, liberal vacation and sick time allowance, pension rights, inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, New York.

WANTED—Qualified staff nurses for city-county health department in educational and cultural center; salary $3,000-$3,600; furnish own car, mileage allowance 6c a mile. Write to Director of Nurses, Health Department, Kalamazoo, Michigan.

WANTED—Public health nurse, elementary school; salary $3,600-$4,000 a year, plus mileage. Write or contact M. A. Brush, Superintendent, Elementary School District, Willows, California.

WANTED—Staff nurses, organized health department; generalized service; salary $3,500-$4,480, automatic annual increments of $140; 5-day week; retirement and accumulative sick leave benefits. Apply to Dr. Philip J. Rafle, Commissioner, Suffolk County Department of Health, Riverhead, Long Island, New York.

WANTED—Experienced supervisor, generalized public health nursing program; college degree; salary $330-$410, car allowance; retirement plan, social security; 5-day week, 4 weeks vacation. Write to Catherine Beermann, Executive Director, Oakland Visiting Nurse Association, Inc., 1432 Grove Street, Oakland 12, California.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,852-$3,536; graduate nurses as assistant PHNs, $2,540-$2,972; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

WANTED—Staff nurses for positions in a generalized program in Wyoming; rural areas and city, county health unit in Cheyenne and Laramie County; beginning salaries $225-$280, depending on qualifications and experience; also, positions for supervisors and director of nursing service; merit system, retirement plan, regular annual increments; career opportunities. Write to Division of Public Health Nursing, State Department of Public Health, Cheyenne, Wyoming.

WANTED—Graduate registered nurses. Staff nursing in maternity and infant care, and gynecology; excellent experience in delivery room and rooming-in plan available; salary $225 a month for 44-hour week, increases in six months, one year, two years; $20 differential for evening and night duty; social security provided. Apply to Superintendent of Nurses, St. Louis Maternity Hospital, 630 South Kingshighway, St. Louis, Missouri.

WANTED—Immediately; supervisor and staff nurses in bi-county health unit in central Illinois, generalized nursing program; supervisor: degree desired, experience required, salary $3,000 to $4,380, depending on qualifications; staff nurse: formal PH training and experience desired, salary $2,640 to $3,660; trainee: salary $2,400, annual increments until maximum. Liberal holiday schedule, 40-hour week, 2 weeks annual leave, 15 days sick leave. Write to Dr. E. M. Thompson, Director, DeWitt-Piatt County Health Unit, 113½ Magill Court, Clinton, Illinois.

WANTED—District field consultant; experienced young woman preferred; master's degree in public health from accredited school required; salary range up to $5,000; travel expenses; Health and Welfare Retirement benefits. Write to Missouri Society for Crippled Children, 3713 Washington Boulevard, Saint Louis, Missouri.

WANTED—Graduate registered nurses. General duty in Medicine, Surgery, Operating Room, and Recovery Room; experience available in Neurosurgery, Chest, Plastic, G.U., et cetera; salary $225 a month for 44-hour week, increases in six months, one year, two years; $20 differential for evening and night duty; social security provided. Apply to Superintendent of Nurses, Barnes Hospital, 600 South Kingshighway Boulevard, St. Louis, Missouri.

WANTED—The expanding National Blood Program of the American National Red Cross offers a different professional nursing specialty to nurses who can fill chief nurse and deputy nurse positions in blood centers. A college degree or at least two years of college work is required, as well as experience in teaching, administration, and public relations. Blood bank or operating room experience is desirable but not required. Inquiries should be directed to Mr. Norman A. Durfee, National Director for Personnel Services, National Headquarters, American National Red Cross, Washington, D.C., and reference should be made to the National Blood Program.

WANTED—Public health nurses for generalized program in suburban area; staff education and students; 5-day week, vacation, sick leave, and retirement benefits. Write to Mr. John Davenport, Personnel Director, The Court House, Arlington County, Virginia.

WANTED—Public health nurses for positions in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57 Street, New York 19, N. Y.

WANTED—Graduate registered nurses. General duty in outpatient department; experience available in all services; salary $225 a month for 44-hour week, increases in six months, one year, two years; social security provided. Apply to Superintendent of Nurses, Washington University Clinics, 607 South Euclid, St. Louis, Missouri.

WANTED—Public health coordinator, school of nursing; 200 students with public health affiliation; large outpatient department; degree required. For details write to Director of Nurses, Jackson Memorial Hospital, Miami 36, Florida.

WANTED—Qualified public health nurse in small community; salary open. Apply to Mrs. Thomas W. Lyons, Chairman, Jamestown Visiting Nurse Association, Jamestown, Rhode Island.

WANTED—Public health nurses and supervisor in tuberculosis, Baltimore County Health Department; population 270,000; suburban, industrialized, and rural areas; county seat 8 miles from Baltimore; generalized service including progressive school program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and special preparation in tuberculosis nursing required; beginning salary $4,000. Public health nurses: qualified, salary $3,000-$3,300; junior nurse, salary $2,600-$2,800; trainee, $2,500. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Physical therapist. Able to take charge of department. 170 bed hospital near Detroit. Maintenance available in nurses' home. Apply: Wyandotte General Hospital, Wyandotte, Michigan.

WANTED—Supervisor and staff nurses; official agency, urban area, population 111,000; generalized service except bedside care; car allowance, personal car required; 40-hour week, sick leave, three weeks vacation, retirement system; supervisor: degree and experience, salary dependent upon qualifications; staff nurses: certified or eligible for certification in Illinois; beginning salary, one semester preparation $2,580, one year preparation $2,700. Write to Director, Division of Public Health Nursing, City Health Department, Peoria, Illinois.

WANTED—Graduate registered nurses. General duty in Eye, Ear, Nose, and Throat services and Psychiatry; salary $225 a month for 44-hour week, increases in six months, one year, two years; $20 differential for evening and night duty; $30 a month additional for Psychiatric Nursing; social security provided. Apply to Superintendent of Nurses, McMillan Hospital, 640 South Kingshighway, St. Louis, Missouri.

WANTED—Immediately. Physical therapists, experienced, preference given to nursing background; near two approved schools of physical therapy, university facilities available locally for educational plans; agency program offers service under medical prescription to patients in their homes, includes care of early subacute poliomyelitis patients, provides supervised experience opportunity for physical therapy students; 5-day week, liberal holiday, vacation, and sick leave allowance. Write to Ruth E. TeLinde, Executive Director, Visiting Nurse Association, 1038 North Cass Street, Milwaukee, Wisconsin.

WANTED—Public health nurses, educational director, consultants in mental hygiene and physiotherapy for combination agency, Ohio capital city, population 400,000; generalized service, including bedside care; 39½-hour week, every other Saturday free, 2 weeks sick leave, 2 weeks vacation, retirement plans; mileage allowance 8c, automobile not required; salaries: educational director, mental hygiene consultant, $4,020-$4,380; nurse physiotherapist, $3,840-$4,200; prepared public health nurses, $3,060-$3,420. Write to Mable E. Grover, Director, Division of Nursing, Columbus Department of Health-Instructive District Nursing Association, City Hall, Columbus 15, Ohio.

WANTED—Qualified staff nurses for generalized program; good retirement; sick leave, vacation. Vacancy with City of San Jose, salary $305-$361 a month. Vacancy with San Jose Unified School District, salary $3,100-$4,300 a year. Apply to Margaret Nelson, Chief Public Health Nurse, City Health Department, 280 S.E. Market Street, San Jose, California.

WANTED—Staff nurses, with new ideas, for positions in local health units in Oregon; at least $260 to start, plus expenses; liberal employee benefits. Write to A. T. Johnson, Merit System Supervisor, 1019 S.W. 10th, Portland 5, Oregon.

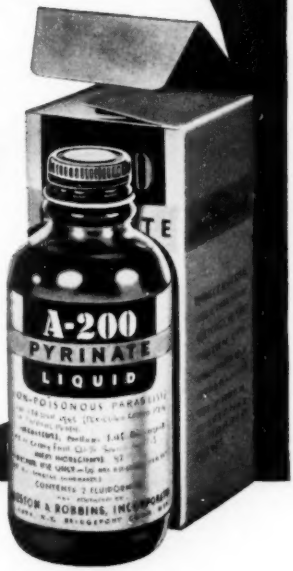
ACCEPTED

BY THE PROFESSION BECAUSE...

A-200

PYRINATE LIQUID

Kills head, crab, body lice and their eggs... on CONTACT!



A-200 Pyrinate Liquid has won quick and general acceptance by the nursing profession wherever it has been introduced. Proven most effective in 8,000 clinical tests, A-200 was developed under strict medical supervision. It is a fast, effective killer of lice and other body parasites... yet is NON-POISONOUS, NON-IRRITATING, AND LEAVES NO TELL-TALE ODOR and, A-200 is easy to use, no greasy salve to stain clothing, quickly applied, easily removed ... one application is usually sufficient.

The active ingredients of A-200 are Pyrethrum extract activated with Sesamin Dinitroanisole, and Olearesin of Parsley fruit, in a detergent-water-soluble base. The Pyrethrins are well-known insecticides and Anisole is a well-known ovicide, almost instantly lethal to lice and their eggs, but harmless to man.

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Be Professionally Correct!

Public Health Uniforms

In NAVY BLUE

Take one or take all . . . and KNOW you've made a wise choice in beautiful fabric, splendid craftsmanship, permanent comfort. POPLIN dresses are made of finest 2-ply, all combed yarn. All styles are available in Long or Short Sleeves. So pretty and so LOW-PRICED, they're EASY to buy NOW.

SIZES 10 to 20; 40 to 46

STYLE 825 POPLIN
Classic shirtmaker, with 2 generous pockets, 6-gore skirt, zipper side fastening, sewed-in belt, smoked pearl buttons. Sanforized. Only $8.50

NOPHN STYLE 666P POPLIN
Sanforized Only $7.95

NOPHN Style illustrated above is also available in

STYLE 666B BROADCLOTH. Superb all-Pima combed yarn. Sanforized. Only $10.45

STYLE 666N NYLON. Soft, shadowproof. Only $14.95

STYLE 9100 POPLIN
7-gore, full fly-front skirt, 3 roomy pockets. Action back, smoked pearl buttons. Sanforized. Only $8.50

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